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ABSTRACT

This manual outlines the State of Oregon's program to reimburse medical providers furnishing health services to students with medical disabilities in special education settings. The program was established to comply with federal provisions of the Individuals with Disabilities Education Act of 1990. The guide will assist school personnel in preparing billings to the Office of Medical Assistance Programs (OMAP) for eligible Medical Assistance Clients participating in the Oregon Health Plan. The sections of the guide are: (1) Program Information, including definitions, provider requirements, enrollment provisions, and services not covered; (2) Billing and Payment, including electronic billing, completion of claim forms, and adjustment requests; (3) Procedure Codes; (4) Accounting, Recordkeeping, and Audits, including record confidentiality; (5) Addendum, including legal basis for Medicaid reimbursement, school-based mental health services, and ICD-9 (International Classification of Disease) code requirements; (6) Medicaid Questions and Answers, including history, screening, and examples of acceptable documentation; and (7) Forms. (RB)

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School-Based Health Services

Administrative Rules

ED 392 532

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December 1, 1995

State of Oregon
Department of Human Resources
Office of Medical Assistance Programs
Salem, Oregon

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School-Based Health Services

Transmittal Record

Use this sheet to record any revisions to this Guide. As replacement pages are inserted into the guide, enter the insertion date across from the corresponding revision number.

Revision Number	Date Inserted
1	
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School-Based Health Services

December 1, 1995

Prepared by:
Program and Policy - Provider Relations
Office of Medical Assistance Programs
Department of Human Resources
State of Oregon

Foreword

The *School-Based Health Services* guide is a user's manual designed to assist education facility providers in preparing billings to the Office of Medical Assistance Programs (OMAP) for eligible Medical Assistance clients. This guide is used in conjunction with the *General Rules for Oregon Medical Assistance Programs* and the *Administrative Rules for the Oregon Health Plan Medicaid Demonstration Project*. Rules and definitions within those guides are applicable to provision of services.

Instructions on completing claim forms, administrative rules and examples of some completed forms are included in this guide. A section listing procedure codes and their definitions, restrictions and limitations is also included. An addendum includes guidelines and criteria which is meant to provide further clarification on billable services and ICD-9 code requirements.

OMAP endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

Providers are responsible for maintaining current publications provided by OMAP.

410-133-000

With the exception of the mental health benefit, <u>everyone</u> with the Basic Health Care Package has the same package of benefits, regardless of their age or which managed health care plan they are enrolled in.

Medicaid clients receive the Basic Health Care Package as soon as they apply and are found eligible.

The Emphasis is on Managed Care . . .

A key to the Oregon Health Plan's cost-effectiveness is *managed care*. By giving each client his or her own primary care practitioner, this system encourages preventive checkups and early diagnosis to keep people healthier and treatment costs down.

Managed care in Oregon comes in several forms:

Fully Capitated Health Plans and **Physician Care Organizations** receive a set monthly fee to cover medical services for each client whose care they manage. Where neither exists, or when clients have special circumstances such as other health insurance, OMAP contracts with individual practitioners as **Primary Care Case Managers,** for a monthly fee plus fees for services. **Dental Care Organizations** receive a set monthly fee to cover dental services for each client whose dental care they manage, as do **Mental Health Organizations** for mental health services.

. . . but Fee-For-Service continues

For a variety of reasons, many providers will still treat some Medicaid patients on a fee-for-service basis:

- Some managed care plans do not provide some services (see table on following page).
- Services for patients with Primary Care Case Managers are always billed fee-for-service (but may require a referral from the PCCM).
- The patient may not yet have enrolled in a managed care plan, or may be "between" plans. (All patients have a lag of up to a month between the time they are eligible for the Basic Health Care Package and when their enrollment in a plan is effective.)
- No plans may be available in the county where the patient lives, or temporarily may not be accepting new enrollment.

Any patient's managed care status may change from month to month: **always check the Medical Care Identification or call the Automated Information System (AIS) before providing services** to any Medicaid patient. If the patient is enrolled in a plan, contact the plan.

Who should use this guide?

Follow this guide when treating Medicaid patients on a **fee-for-service** basis. Always follow the appropriate plan's procedures when treating patients with managed care plans listed on the Medical Care Identification.

PM5:MK:New OHP Info Sheet:11/94

Medicaid and the Oregon Health Plan

On Feb. 1, 1994, Oregon began expanding its Medicaid program under the **Oregon Health Plan** (OHP). This meant changes in eligibility, benefits and service delivery for most current Medicaid clients and new coverage for 120,000 low-income men, women and children.

After January 1, 1995, *nearly all* the Medicaid patients you see will be covered under the **Basic Health Care Package.** However, a small number of Medicaid clients will *not* have the Basic Health Care Package:

- Certain Medicare beneficiaries have the "**QMB**" package, which pays Medicare premiums, copays and deductibles only.
- Some people with incomes above the federal poverty level but with heavy medical expenses are still covered under the state "Medically Needy" program and receive the **Limited Medicaid Package** (prescription drugs, mental health and chemical dependency services, and medical transportation to access those services).
- Others have the "**QMB + Limited**" package, which pays Medicare premiums, copays and deductibles, prescription drugs, mental health and chemical dependency services, and medical transportation to access those services.

Who is Covered by OHP?

- Families, couples and single people under age 65 with household incomes under the federal poverty level.
- Pregnant women and children under 6 with household incomes under 133% of the federal poverty level.
- Children in state foster care.
- Aged, blind and disabled persons who receive SSI or who are in nursing facilities.

Who is Not Covered by OHP?

- Anyone with income above the limits set by the legislature
- People eligible for Medicare who do not qualify for Medicaid in a "traditional" category, even if their income is below the federal poverty level.
- Undocumented aliens, except for emergency care.

The Basic Health Care Package

The Basic Health Care Package is based on a list of paired medical conditions and their effective treatments (known as the **Prioritized List**). This package includes:

- Diagnosis and screening for all conditions on the list, even those whose treatment may not be covered
- Routine physicals, mammograms, obstetrical care, and well-child exams
- Dental and vision care for adults and children
- Prescription drugs
- Hospice care
- Most organ transplants
- As of Jan. 1, 1995, chemical dependency services. These services will be provided through managed care plans beginning Feb. 1, 1995.

Beginning Jan. 1, 1995, mental health benefits are included on the Prioritized List for Medicaid clients in 20 counties. Medicaid clients outside the 20-county area are scheduled to receive the mental health benefit beginning July 1, 1996.

State of Oregon
Department of Human Resources
Office of Medical Assistance Programs

Title of Guide School-Based Health Services

EVALUATION FOR PROVIDER GUIDES

This Guide was written to assist you in providing services under the Medical Assistance Programs. After you have used this publication, please send your comments to the Provider Relations Unit, Office of Medical Assistance Programs. If you would rather telephone, call us at 945-6738. This response form is provided for your convenience.

PLEASE RESPOND so that your views can be considered as we plan future revisions. Remove the form from the guide, enter your comments, fold, staple, and mail it back to us. We want to hear from you.

Did you find the content to be stated clearly and accurately?

- ❑ Yes, clear and accurate
- ❑ Mostly, clear and accurate
- ❑ Somewhat, clear and accurate
- ❑ Other _____

Were the contents presented in a convenient format?

- ❑ Very easy to use
- ❑ Fairly easy to use
- ❑ Very difficult
- ❑ Other _____

In what capacity were you using the guide?

- ❑ Billing
- ❑ Practitioner
- ❑ Other _____

When the guide is revised, what changes would you like to see made?

_____

_____

_____

_____

Please list your suggestions for provider training.

_____

_____

_____

Additional comments. Use specific examples if you have any. (Attach a sheet if you wish)

_____

_____

_____

OMAP 1273 (Rev 4/93)

From

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PRU – OMAP
500 Summer St NE
Salem, Oregon 97310-1014

November 30, 1995

Oregon
DEPARTMENT OF
HUMAN RESOURCES
Human Resources Building
OFFICE OF MEDICAL
ASSISTANCE
PROGRAMS

TO: School Medical Providers

SUBJECT: *School-Based Health Services* Provider guide -- Revised and Reissued

EFFECTIVE DATE: December 1, 1995

The *School-Based Health Services* provider guide is revised and reissued, effective December 1, 1995. Please read the guide carefully because there are significant changes throughout. Major changes include:

- The addition of an Addendum to the provider guide. The Addendum provides specific information and instructions to assist school personnel in accessing medical reimbursement. The Addendum contains:
  - A comprehensive introduction to and history of school-based health services.
  - Examples of situations where services are covered or not covered.
  - A section listing the most common questions and answers received from school personnel.
  - A detailed explanation of changes to the school-based health services program as a result of the Oregon Health Plan.
  - A list of diagnosis codes commonly used by school-based health service providers.
  - Information relating to Medicaid eligibility; documentation for tests, assessment and evaluations and examples of procedures to be used to determine billing costs are also included in the Addendum.
- Definitions are revised. The following definitions are added:
  - Billing Time Limit
  - Conference
  - Direct Services
  - Licensure
  - Observation
  - Third Party Billing
  - Treatment Plan
- The lists of covered and not covered services are updated.
- Billing instructions are revised to require a diagnosis code.
- Procedure code descriptions and criteria are updated.

John A. Kitzhaber
Governor

500 Summer Street NE
Salem OR 97310-1014
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FAX - (503) 373-7689
TDD - (503) 378-6791

HRB 1014 (Rev. 2/95)

For services provided prior to December 1, 1995, continue to use the September 1, 1991 *School-Based Health Services* guide.

Questions

If you have any questions about claims, payment or policy, contact a Provider Services Representative between 9:00 am and 4:00 pm at toll-free 1-800-336-6016.

Sincerely,

Hersh Crawford

Hersh Crawford, Acting Director
Office of Medical Assistance Programs, DHR

Program Information

410-133-020 Purpose

The Oregon Administrative Rules in Chapter 581, Division 15 for the Department of Education outline Oregon's program to meet the federal provisions of the Individuals with Disabilities Education Act of 1990. The rules of School-Based Health Services define Oregon's program to reimburse the health services provided under the Act to Oregon's Medicaid-eligible children.

The Oregon Department of Education and the Office of Medical Assistance Programs recognize the unique intent of health services provided for medical disabilities in the special education setting. The School-Based Health Services Guide addresses the health aspects of special education services.

410-133-040 Definitions

Adequate Recordkeeping – Documentation in the student file that shows that the health services provided to the student and billed to the Office of Medical Assistance Programs (OMAP) are in compliance with OMAP rules. (See 410-133-300)

Assessment – Used in determining eligibility for Medicaid related services, obtaining information about the student and yielding outcomes that are helpful for developing Individual Education Programs/Plans. An IEP Assessment is helpful in determining short term objectives and documenting progress. Assessment is also used after plans are established and there is the need for further information gathering to restructure the IEP.

Augmentative Communication Services – Are services provided by Augmentative Communication Specialist with training and expertise in the use of alternative communication systems.

Billing Time Limit – Refers to the rules concerning the period of time allowed to bill a service to OMAP under "Timely Submission of Claims", General Rule 410-120-340.

Certification – See "licensure."

Conference – A scheduled meeting, regarding a student with special needs, between several interested parties. A conference might be one of the following: an MDT meeting to determine a child's early intervention or special education eligibility, an IEP or IFSP meeting to plan a child's appropriate educational program or early intervention plan, a child study team meeting to discuss the child's progress, or a meeting with other health care professionals to discuss the child's medical, educational or early intervention needs.

Consultation – Services that are provided by health care professionals, under the scope of their licensure, to other professionals or family members. These services or expertise are related to specific goals and objectives in a student's IEP.

Delegation of Task – A non-licensed person assigned by a registered nurse to perform selected tasks of nursing care which are identified in the nursing care/health management plan as part of the IEP/IFSP.

Department – Refers to the Oregon Department of Education.

Direct Services – Personal interventions of the service provider with the student.

Early Childhood Special Education – Specially designed instruction to meet the unique needs of a preschool child (three years of age until the eligible age for kindergarten) with a disability. Instruction may be provided in any of the following settings: home, hospitals, institutions, special schools, classrooms, and community child care or preschool settings or both.

Early Intervention – A state operated program designed to address the unique needs of preschool children (ages zero to three) with a disability.

Educational Assistant – See Health Care Aide.

Education Entity – A local school district, Department of Education regional program, Education Service District, state-operated institution or facility.

Education Service District (ESD) – An education entity established to offer a resource pool of cost effective, education-related, state-mandated services to multiple local school districts within geographic areas described in ORS 334. ESD's have cooperative relationships to furnish student services beyond the capability of individual schools in the assigned geographic area.

Eligibility for Special Education – A child meets the eligibility criteria for early intervention, early childhood special education or special education as defined in ORS 343 and OAR, Chapter 581, Division 15.

Evaluation – Assessment procedures to determine a child's specific needs under IDEA and in accordance with OAR 581-15-071, and which must be completed by licensed health care providers practicing under the scope of their licensure.

HCFA-1500 – The standard billing form used to bill medical services. HCFA is an acronym for Health Care Financing Administration.

Health Care Aide/Delegated Health Care Aide – A non-licensed person assigned by a Registered Nurse to perform selected tasks of nursing care identified in the Nursing Care/Health Management Plan as part of the IEP/IFSP.

Health Services – The medical evaluation, testing and/or treatment services required to achieve the health/education related goals set forth in a child's IEP or IFSP so the child can benefit from a special education program (3-21) or an early intervention program.

ID Number – The number issued by the DHR agency used to identify Medicaid clients. May also be referred to as Recipient Identification Number; Prime Number; Client Medical ID Number or Medicaid ID Number.

IEP Team – An IEP team is responsible for developing, reviewing and revising a handicapped child's IEP and includes participants as required by OAR Chapter 581, Division 15.

Individualized Education Plan (IEP) – A plan developed and implemented under OAR Chapter 581, Division 15, for each disabled school age child eligible for special education and related services. The plan is designed to meet the individual needs of the child which address the child's disabilities as they impair the child's functioning, learning and educational progress. The IEP addresses disabilities that will continue and cannot be resolved by short-term therapies.

Individualized Family Service Plan (IFSP) – A written plan of early childhood, special education, related services, early intervention services and other services developed in accordance with requirements set forth in OAR Chapter 581, Division 15, to meet the needs of a child with disabilities as defined by OAR Chapter 581, Division 15, from birth to the age of eligibility into kindergarten.

Intervention Activity – A term sometimes used in the educational setting to indicate a service or treatment.

Licensure – The process of state agencies insuring licensure which shows that those licensed are qualified to perform specific duties and services within a legal standard recognized by that agency.

Medical Services – The care and treatment provided by a licensed medical provider to prevent, diagnose, treat, correct or address a medical problem, whether physical, mental or emotional. For the purpose of this guide, this term shall be synonymous with health-related services required by an IEP, or IFSP, as defined in OAR Chapter 581, Division 15.

Medically Qualified Staff – Staff employed by and/or through contract with a School Medical Provider who meet qualification under State law and rule 410-133-120.

Multidisciplinary Team (MDT) – A team of people who determine a child's eligibility for special education and the special education placement of the child following the development of an Individual Education Program (IEP) or an Individualized Family Service Plan (IFSP).

Nursing Care Plan (Health Management Plan) – The plan of care established to meet the health needs of a child in the educational setting.

Nursing Services – Health care services required by IEP or IFSP and provided to an eligible child by a registered professional nurse, a licensed practical nurse or delegated health care aide, within the scope of practice as defined by State law. Nursing services include preparation of treatment plans, consultation and coordination of service activities as well as direct patient care and supervision.

Observation – A service performed by a medical provider in an attempt to better understand the child's needs, skills and progress by observing the student in their natural environment.

OMAP Rate – The amount OMAP will reimburse for a service.

Orientation and Mobility Training – Evaluation and training provided by a certified or equivalently trained Orientation and Mobility Specialist to correct or alleviate mobility difficulties created by a loss or lack of vision.

Prime Number – See definition of ID number.

Provider Agreement – A contract between the Medical Assistance Program and an enrolled Medical Assistance provider which commits both parties to the provisions of the Medical Assistance Program General Rules and related guide rules.

Qualified Provider/School Medical Provider (SM) – Within the context of this guide, this term means a provider who is certified by the Department of Education and OMAP as qualified to perform IEP/IFSP School-Based services under the Medical Assistance program as Educational Entity.

Recipient – See Client in the General Rules. This term is synonymous with "student" or "child" in this guide.

Regional Program – Special Education, Early Childhood Special Education, Early Intervention and/or related services provided on a multi-county basis, under contract from the Department of Education. These programs provide services to eligible children who are visually impaired, hearing impaired, deaf-blind, autistic, and/or severely orthopedically impaired.

Rehabilitative Services – For purposes of this guide, any medical, psychological or remedial service recommended by a physician or other licensed practitioner within the scope of his practice under State law, for reduction, correction, stabilization or functioning improvement of physical or mental disability of a client (See 410-133-060).

Related Services – Transportation and such developmental, corrective, and other supportive services which may be required to assist a child with disabilities to benefit from early intervention or special education. Services include speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training. (Not all related services are Medicaid covered.)

School-Based Health Services – A related health service required by an IEP or IFSP during a child's education or preschool program. (See 410-133-060)

School Medical Provider (SM) – A provider type established by OMAP to designate the provider of school-based health services.

Screening – A limited examination to determine a child's level of functioning ability in areas such as hearing, speech, vision, motor skills, learning abilities, mental processes, or to determine the existence of a disabling condition. Screening is often followed by more extensive testing and/or evaluation if a disability is suspected.

Special Education Services – Specially designed instruction to meet the unique needs of a child with a disability, including regular classroom instruction, instruction in physical education, home instruction, and instruction in hospitals, institutions, special schools, and other settings.

State Education Agency (SEA) – The Oregon Department of Education which provides oversight to public education entities for ensuring compliance with Federal and Oregon state laws relating to the provision of services required by the Individuals with Disabilities Education Act of 1990 (IDEA).

State-Operated Schools – Facilities such as the Oregon School for the Blind or the Oregon School for the Deaf, that are operated by the Department of Education to address specific student disabilities.

Student Health/Medical/Nursing Records – Records kept in the student's education file that document for Medicaid purposes the child's diagnosis or the results of tests, screens or treatments; treatment plan; the IEP or IFSP; and the record of treatments given to this child. Those records created by health professionals as required by their scope of practice to document Medicaid covered services to Medicaid eligible students. (410-133-300).

Teachers Standards and Practices Commission (TSPC) – Commission which governs licensing of teachers, personnel service specialists, and administrators as set forth in OAR 584-36-005 through 584-52-027.

Testing – See "Assessment."

Third-Party Billing – Third-party billing is the process of sending a bill to a public or private insurance company for a medical or health service given to someone who is insured.

Transportation as a Related Service – Refers to transportation to Medicaid eligible services that are described on the IEP/IFSP and under the procedure code RS 118 in rule 410-133-300 of this guide.

Treatment Plans – A child-specific plan as defined by the IEP/IFSP or health management/nursing care plan.

410-133-060 Health Services

School-based health service is a health service which:

- addresses physical or mental disabilities of a child; and
- is identified in a child's Individual Education Program/Plan (IEP), Individualized Family Service Plan (IFSP), or Health Management Plan; and
- is recommended by a physician or other licensed practitioner within the scope of practice under State law.

School-based health services may be:

- Psychological services and evaluations
- Nursing evaluations and services
- Physical and occupational therapy and evaluations
- Speech evaluations and therapy
- Audiology evaluation and services
- Vision evaluation and services
- Medical evaluations

410-133-080 Coverage

The Office of Medical Assistance Programs will reimburse for the following services:

- Health services required by a child's IEP or IFSP or similar plan;
- Evaluation and testing services necessary to determine a child's participation in an individualized plan;
- Transportation services as documented in the child's IEP and defined in this guide;
- Evaluation and transportation services for the child's IFSP provided by the Local Education Agency (LEA);
- Rehabilitative health activities under Part B or H of the Individuals with Disabilities Education Act of 1990. Only Low-Incidence Regional Programs enrolled as School Medical Providers may bill for IFSP health related services.

410-133-090 Provider Payment

Payment will be made to the enrolled education entity as the performing provider for those services provided by the employed staff person. While the education entity shall hold primary responsibility for providing these services with its own qualified staff, it may also contract, on a supplemental basis only, for covered services with individuals or organizations that meet qualifications for medical staff as outlined in rule 410-133-120.

410-133-100 Provider Requirements

The School Medical provider is responsible to:

- provide services required in the child's individual plan for special education under OAR Chapter 581, Division 15;
- provide services through staff who are medically qualified to perform the service;
- provide appropriate medical supervision for delegated tasks;
- document service in writing as required in OAR 410-133-120;
- maintain adequate records in the student file;
- make the records required by OAR 410-133-320 and other rules of this guide available for a period of five years;
- establish a schedule of fees;
- provide access for on-site review of students' records and provisions of service;
- document any changes in the IEP plan (IFSP if applicable) related to treatment;
- assure that services billed reflect health services and do not reimburse education services;
- comply with all applicable provisions of the OMAP General Rules.

410-133-120 Medically Qualified Staff and Services

The School Medical provider shall furnish reimbursable services through the following qualified staff who provide services within the scope of their licensure:

- Physical or occupational therapy treatments shall be provided by licensed physical therapists, licensed occupational therapists, licensed physical therapy assistants or certified occupational therapy assistants within the scope of their licensure. Physical or occupational therapy evaluations and treatment plan development can only be provided by licensed physical therapists or licensed occupational therapists. Special education teachers are not recognized as medically qualified staff for these services.
- Medical evaluations, assessments or testing are services that are provided by licensed physicians and osteopaths.
- Nursing evaluations and treatment for disabled children shall be provided by licensed Registered Nurses, Licensed Practical Nurses or licensed Nurse Practitioners within the scope of their licensure. Delegated nursing tasks shall be provided by trained health care aides.

- Psychological evaluations, testing, psychological services and/or treatments shall be provided by individuals who meet the relevant requirements of the Teacher Standards and Practices Commission and/or professional state licensure. Individuals who meet those requirements include: Basic School Psychologist (584-44-014), Standard School Psychologist (584-44-023), Standard Counselor (584-44-023), Child Development Specialist with Master's Degree (584-23-050), Standard Handicapped Learner Endorsement I or II with Master's Degree (584-40-260; 584-40-265), licensed physician, licensed psychologist, licensed psychiatrist, licensed clinical social worker, and licensed counselor.
- Speech therapy treatments and speech therapy evaluations shall be provided by speech pathologists who are licensed either by the Board of Speech Examiners in Speech Pathology and Audiology or hold the American Speech and Hearing Association (ASHA) Certificate of Clinical Competence (CCC) or a graduate speech pathologist being supervised in the Clinical Fellowship Year (CFY).
- Audiological evaluations/screenings and services shall be provided by licensed audiologists or licensed audiometrists within the scope of State Law.
- Vision services shall be provided by licensed ophthalmologists or optometrists for services within the scope of their licensure. Trained orientation and mobility specialists with TSPC licensure with an endorsement in the area of Visually Impaired or AER (Association for Education and Rehabilitation) Division 9 Orientation and Mobility Specialist Certification can provide services eligible for reimbursement.
- Delegated Health Care Services shall be provided by medically trained health care aides or trained transportation attendants specifically trained by a registered nurse or nurse practitioner, within the scope of their licensure, to provide medical services to children with disabilities under supervision of the licensed professional.

410-133-140 Enrollment Provisions

Providers of School Medical Health Services will be certified to OMAP by the Oregon Department of Education as qualified to be enrolled as School Medical providers.

The provider enrollment process will consist of:

- Certifying letters of approval from the Oregon Department of Education
- Enrollment with the Office of Medical Assistance Programs

An approved enrollment application is a contracting agreement that binds the provider to comply with OMAP General Rules and OMAP guide rules.

410-133-160 Licensed Practitioner Recommendation

Requests for payment of medical services required by a child's individualized plan must be supported by written documentation of a licensed medical practitioner recommending the service. The recommendation must be updated annually and can be satisfied by the annual IEP/IFSP review process.

410-133-180 Duplication of Service

A contracted provider may only bill OMAP for services when the School Medical provider and the contracted provider have previously agreed that the School Medical provider will not also bill for the same service.

Duplicate billings are not allowed and payments will be recovered. Services will be considered as duplicate if:

- the same services are billed by more than one educational entity to address the same need; e.g., an Education Service District and a local school district cannot bill for the same services provided to the student.

A unit of service can only be billed once; under one procedure code, under one provider number.

410-133-200 Not Covered Services

Education-based costs normally incurred to operate a school and provide an education are not covered for payment by OMAP.

Medical care not related to the child's individualized plan is not covered for payment by OMAP, under the School-Based Health Services program.

Also not covered are:

- Activities related to researching student names, determine Medicaid eligibility status, administrative activities such as data entry of HCFA-1500 claim forms, travel time by service provider(s). Administrative costs related to health services and recordkeeping have been calculated into the payment rates.
- Family Therapy where the focus of treatment is the family.
- Routine health nursing services provided to all students by school nurses; nursing intervention for students who become ill or injured in the school setting.
- Educational workshops, training classes, parent training. (Exception: delegated, but child specific training by an RN or Nurse Practitioner, within the scope and practice of their licensure, to a health care aide or transportation attendant.
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Procedure Codes

410-133-220 Billing and Payment

The School Medical provider must bill OMAP at a rate no greater than the rate established by the provider for billing the service to any other resource. Payment by OMAP will not exceed established rates.

Services must be billed on a HCFA-1500 or by electronic media claims (EMC) submission using only those procedure codes found in the *School-Based Health Services* guide.

OMAP will accept a claim up to 12 months from the date of service.

HCFA-1500 forms are not provided by OMAP. A common source for getting these forms is a local forms supplier.

Send all completed HCFA-1500 forms to:

Office of Medical Assistance Programs
PO Box 14955
Salem, OR 97309

Electronic Billing

HCFA-1500 claims can be submitted on a 3480 cartridge or by computer over the telephone via modem or on floppy disk. For more information contact a Provider Services Representative at:

PRU - OMAP
500 Summer St NE
Salem, Oregon 97310-1014
Telephone: 1-800-336-6016

410-133-240 How to complete a HCFA 1500

If there is not enough space on the HCFA-1500 to bill all procedures provided, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another.

1a. **Insured's I.D. Number:** Enter student's eight digit number as it appears on the Medicaid records or is given by AIS.

2. **Patient (Student) Name:** Enter the name as it appears in the Medicaid records. Enter last name first, first name, middle initial. If the Medicaid records show Robert Smith, but school records show Bob Smith, the billing must be under Robert Smith. (Field 26 may be used to cross-reference to school records - information up to 12 characters entered here will print out on the Remittance Advice.)

3. **Date of Birth:** Enter the student date of birth.

*9. **Other Insured's Name:** Use NC as an indication the insurer does not cover the procedure.

21. **Diagnosis:** Enter the diagnosis/condition of the patient indicated by current ICD-9-CM code number (can use primary diagnosis). Carry the codes out to their highest degree of specificity (fourth or fifth digit).

24A. **Date of Service:** Must be a six-digit (05/03/95—mm/dd/yy) numerical date. If one of the cumulative codes is billed, use the last day of service during the month. Otherwise, use the specific date of service. For transportation, use the last date of transport during the month being billed.

24B. **Place of Service:** Enter B to indicate the school district facility.

24C. **Type of Service Codes (TOS):** Use Type of Service "S".

24D. **Procedures, Services or Supplies:** Enter the most appropriate unique procedure code listed in the School-Based Health Services guide. Use only one code to bill a unit of time. (For example do not bill both RS 112 and RS 110 for the same time period.)

24E. **Diagnosis Code:** Enter the one-digit line number which refers to the diagnosis from field 21 for each service billed.

24F. **Charges:** Enter the total charge for each line item. If billing more than one unit of service you will reflect the multiplied total cost in 24F for that procedure code line.

24G. **Days or Units:** Enter the total number of units or services provided for each procedure code billed. For procedures billed for a single date of service, enter the total units of service under that code for that day. For codes that are billed for services added up to the last date of service, use the cumulative total of units under that code for the month as the number of units billed.

26. **Patient's Account Number:** Optional - if a patient account number is entered here, OMAP will print the account number on the Remittance Advice.

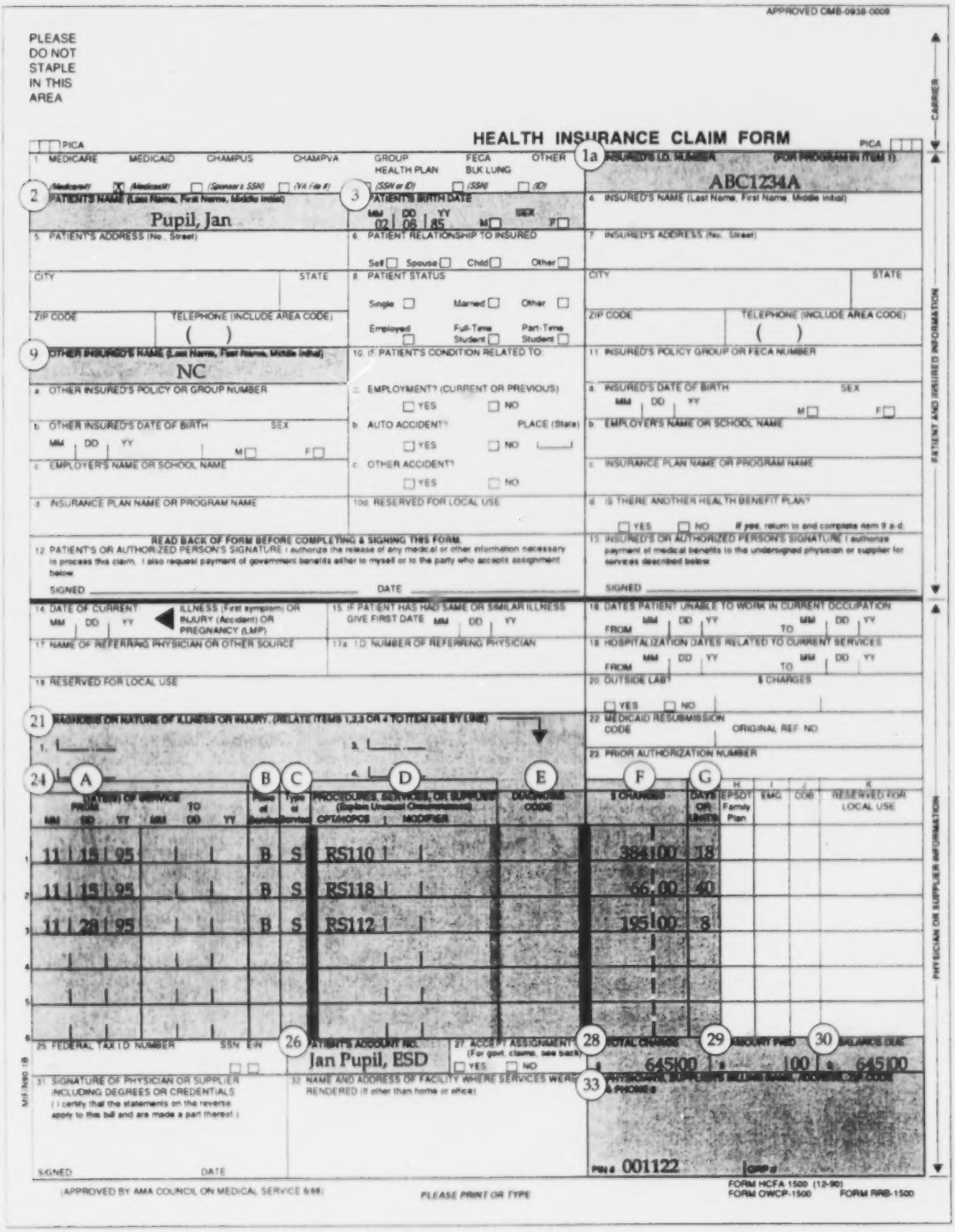
28. **Total Charge:** Enter the total of all the charges listed in column F.

*29. **Amount Paid:** Enter the total amount paid from other resources.

30. **Balance Due:** Enter the balance (Field 28 minus Field 29).

33. **Provider Number:** Enter the OMAP assigned six-digit School Medical provider number here.

***Required when applicable. All other fields are required unless noted.**



APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

1 MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): ABC1234A

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Pupil, Jan

3 PATIENT'S BIRTH DATE: 02 08 85 SEX M F

4 INSURED'S NAME (Last Name, First Name, Middle Initial)

5 PATIENT'S ADDRESS (No., Street)

6 PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7 INSURED'S ADDRESS (No., Street)

CITY | STATE

8 PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NC

10 IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR FECA NUMBER

a OTHER INSURED'S POLICY OR GROUP NUMBER

a EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a INSURED'S DATE OF BIRTH MM DD YY SEX M F

b OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b AUTO ACCIDENT? YES NO PLACE (State)

b EMPLOYER'S NAME OR SCHOOL NAME

c EMPLOYER'S NAME OR SCHOOL NAME

c OTHER ACCIDENT? YES NO

c INSURANCE PLAN NAME OR PROGRAM NAME

d INSURANCE PLAN NAME OR PROGRAM NAME

10d RESERVED FOR LOCAL USE

d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14 DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a I.D. NUMBER OF REFERRING PHYSICIAN

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19 RESERVED FOR LOCAL USE

20 OUTSIDE LAB? YES NO $ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22 MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	11 15 95		B	S	RS110			384 00	18				
2	11 15 95		B	S	RS118			66 00	40				
3	11 28 95		B	S	RS112			195 00	8				
4													
5													
6													

25 FEDERAL TAX I.D. NUMBER SSN EIN

26 PATIENT'S ACCOUNT NO. Jan Pupil, BSD

27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28 TOTAL CHARGE $ 645 00

29 AMOUNT PAID $ 00

30 BALANCE DUE $ 645 00

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# 001122 GRP#

MS 1500 (8)

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA 1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Instructions for Remittance Advice

A Remittance Advice (RA) is the automated notice received from OMAP explaining payment or other claims actions. This is the only notice regarding claims actions you will receive. Claims that are "in process" will not appear on the RA. The information on the RA is the information OMAP used to process the claim. If an incorrect payment is received, submit an Adjustment Request Form, OMAP 1036. If no payment was made, the RA will tell you to resubmit or adjust the claim.

1. **Provider Name and Number:** The name of the provider and the OMAP provider number will appear here.
2. **Date:** This is the date the RA was printed. The date on the check will be the same when a check is issued with RA.
3. **RA#:** This is the unique number OMAP assigns each RA; however inquiries about the RA should refer to the date of the RA rather than this number.
4. **Page:** This is the sequential page number for this RA.
5. **Recipient's Name:** The name of the client as shown in OMAP records; if the computer does not match the name given with the recipient ID number on the HCFA, the first two letters of the last name used and the first letter of the first name will print here. The claim will not pay until the name/number are correct.
6. **Recipient ID Number:** The client's ID number will appear here.
7. **Internal Control Number (ICN):** This column contains the unique number assigned by OMAP to each claim during processing. Reference this number when completing the adjustment form.
8. **Patient Account Number:** If a patient account number is listed on the HCFA-1500 in Field 26, it will appear here.
9. **Service Date:** This is the date of service as listed on the HCFA-1500 in Field 24A.
10. **TOS/PROC Code:** The Type of Service Code from Field 24C and the procedure code from Field 24D for each line item. An error or omission in this column could explain a denial of payment.
11. **Quantity:** This is the number of units of service from Field 24G billed for the procedure code.
12. **Billed Amount:** This is the amount for each line of Field 24F of the HCFA-1500.
13. **TPL Cred Applied:** The payment amounts from other sources reported in Field 29 of the HCFA-1500.
14. **Payment Amount:** This is the amount OMAP is paying.
15. **Messages:** This column contains numbers which correspond to the written messages at the end of the RA.
16. **Provider Totals:** These are the subtotals from the Billed Amounts, TPL CRED Applied and OMAP Payment Amounts for this RA.
17. **Provider Earnings Information:** This section of the RA contains payment information in two columns: Current (payments this RA) and Year to Date (all payments for this calendar year). Gross Reimbursement Authorized is the maximum amount OMAP could pay for these claims. + Additional Payment Included - an adjustment process that creates further payment. - Recoupment Amount Withheld - an adjustment action resulting in a recoupment of funds that may be shown on this Remittance Advice or may be the result of an adjustment shown on a previous RA.
18. **Claims Message Codes:** These are the computer messages that tell how OMAP processed each claim, why OMAP could not process payment, or what further information or correction may be needed before the claim can be paid.

**** Professional Remittance Advice**** (1) (3) **RA#** 956719557 **Zip** 97000

Provider Name/Number: **Sample ESD 001122** Date: **11/30/95** (2) (4) **Page** 1

(5) Recipient Name	(6) Recipient ID	(7) ICN	(8) Patient Account	(9) Service Dates From	Thru	(10) TOS/Proc Code	(11) Qty	(12) Billed Amount	(13) TPL Cred Applied	(14) Payment Amount	(15) ***Messages***
Hall, Chr	BA22331C	1091086278360		11-08-95	11-08-95	S-RS120	1	135.00	00	121.50	432
SMITH, ROB	BE11223D	1091130312150	Jones, Bob	11-20-95	11-20-95	S-RS110	38	760.00	.00	608.00	093
				11-20-95	11-20-95	S-RS118	10	20.00	.00	16.50	093
				11-20-95	11-20-95	S-RS112	4	100.00	.00	66.00	093
				11-06-95	11-06-95	S-RS114	3	75.00	.00	48.00	093
			Claim Totals					955.00		738.50	
Saxon, Ali	CAB2210E	1091086278390		11-13-95	11-13-95	S-RS120	1	91.00	.00	.00	003
Tien, Eli	KVA0015G	5091143766026	Tien, Betsy	11-17-95	11-17-95	S-RS110	5	89.00	.00	.00	084
Tien, Eli	KVA0015G		Tien, Betsy	11-17-95	11-17-95	S-RS110	5	-89.00	.00	-85.00	
				Provider Totals				1181.00	00	775.00	

(16)

(17)

********* Provider Earnings Information *********

	- Current-	-Year to Date-
Total Claims	4	110
Total Amount Billed	1181.00	
Gross Reimbursement Authorized	860.00	43,971.93
+ Additional Payment Included	.00	.00
- Recoupment Amount Withheld	85.00	-85.00
Payment Amount	775.00	43,886.93
Refunds Credited to Earnings	.00	.00

(18)

********* Claims Message Codes *********

093 Payment at maximum allowable rate.

003 Our records show recipient ineligible on date of service. Contact appropriate AFS/ SDSD branch office for assistance.

084 We have adjusted this claim to reconcile an overpayment made to you.

432 Recipient number was corrected. Use correct number to avoid payment delay.

410-133-260 Adjustment Requests

Overpayments, underpayments and payments received from other sources after OMAP has paid a claim must be resolved through the adjustment process. Obtain Individual Adjustment Request forms (form OMAP 1036) from the AFS Provider Forms Distribution Center at PO Box 14090, Salem, Oregon 97309-4090. Note: Much of the information required on the Adjustment Request form is printed on the Remittance Advice. Documentation must be submitted to support your request. Adjustment requests must be submitted by completing the Form 1036 and mailing to: Office of Medical Assistance Programs, PO Box 14952, Salem, Oregon 97309.

How to Complete an Adjustment Request

1. Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much).
2. This is a reminder to attach needed documentation.
3. Mail the Adjustment Request to this address.
4. Enter the 13 digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in this guide.)
5. Enter the client's recipient identification number in this space. This number can be found on the RA in Field 6.
6. Enter the client's name in this area. Use the name as shown in the Medicaid records.
7. Enter the six digit School Medical provider number from your Remittance Advice in this space.
8. This space is for the provider name.
9. Enter the date printed at the top of the RA.
10. **Description** - This column contains possible areas that may need to be corrected. Only check the box you want to change.

    Place of Service - Use Place of Service B indicator from HCFA-1500 instructions.

    Type of Service - Use Type of Service S.

    Quantity/Unit - The number of services being billed (Field 24G on the HCFA-1500 or Field 10 on the RA).

    NDC/Procedure Code - Codes from this guide must be used (Field 24D on the HCFA-1500 or Field 10 on the RA).

    Revenue Center Code (Hospital Only) - Do not check this box. This is for hospital billing only.

    Insurance Payment/Patient Liability - The payments from other sources (Field 29 on the HCFA-1500 or Field 13 on the RA).

    Drug Name (Pharmacy Only) - Do not check this box. This is for pharmacy billing only.

    Billed Amount - The amount billed OMAP (Field 24F on the HCFA-1500 or Field 12 on the RA).

    Other - Use this box if none of the above address your problems.
11. **Line #:** List the line number from the original claim (HCFA-1500) which needs to be adjusted.
12. **Service Date** - Enter the date the service was performed.
13. **Wrong Information** - Enter the incorrect information submitted on the original claim here.
14. **Right Information** - Enter the corrected information in this column.
15. **Remarks** - this is the area to give additional information or explain your request.
16. **Provider's Signature** - The signature of the provider or other authorized personnel must be in this space.
17. **Date** - Enter the date this form was completed. 30

State of Oregon
Department of Human Resources
Office of Medical Assistance Programs

Individual Adjustment Request

- Complete this form to request an adjustment.
- Please keep your copy.

OMAP Use Only

(1) Please Adjust (indicate situation below)

☒ Underpayment - Request additional payment ☐ Overpayment - Please deduct from subsequent payment

(2) To facilitate processing please attach the following:

- Claim (copy)
- Remittance Advice (copy)
- Financial planner (N.H. only)

(3) Return To:
Office of Medical Assistance Programs
Department of Human Resources
PO Box 14952
Salem OR 97309

Please enter the following data from your Remittance Advice

(4) Internal Control Number: 1 0 9 1 2 1 0 3 2 5 0 7 4

(5) Client I.D. Number: A B 1 2 3 4 0 C

(6) Client Name: Pupil, Jan

(7) Provider Number: 0 0 1 1 2 2

(8) Provider Name: Sample ESD

(9) Remittance Advice Date: 11/30/95

(10) Description	(11) Line No.	(12) Service Date	(13) Wrong Information	(14) Right Information
☐ Place of Service				
☐ Type of Service				
☒ Quantity/Unit	1	11/15/95	12 units 11/15/95	18 units 11/25/95
☐ NDC/Procedure Code				
☐ Revenue Center Code (Hospital Only)				
☐ Insurance Payment/Patient Liability				
☐ Drug Name (Pharmacy Only)				
☐ Billed Amount				
☐ Other				

(15) Remarks: Billed before all services were reported for the month

(16) Provider's Signature: *Sample ESD*

(17) Date: 12/01/95

Distribution: White - OMAP, Canary - Provider

OMAP 1035 (Rev. 3/90)

31

410-133-280 Rebilling

In order to correct a claim that does not include all services given during the same time period, the provider must request an adjustment. The paid claim must be corrected on the Individual Adjustment Request form (OMAP 1036) to allow revision of the original claim. Rebilling additional units of service on a HCFA-1500 for the same timeframe would be denied as duplicate services.

Billing and Payment

410-133-300 Procedure Codes

The provider must use the procedure code from the School-Based Health Services guide which best describes the specific service or item provided. Unit values equal 15 minutes of service unless otherwise stated. These time units must be documented in the child's records under the services billed. Account for each unit of service under one code only.

Procedure Codes

RS 110 Basic Health Service

Maximum limited to 264 units per month.

Includes reimbursement for corrective treatments (individual and group) and related activities as described in a student's individual plan and the preparation of written records for those treatments. These services must be provided by personnel who meet the standards of licensing or certification for the service being provided:

- licensed physical or occupational therapist;
- licensed physical therapy assistant or certified occupational therapy assistant;
- licensed speech pathologist;
- licensed audiologist or audiometrist;
- licensed ophthalmologist or optometrist;
- licensed psychologist;
- licensed psychiatrist;
- licensed clinical social worker;
- licensed counselor;
- basic school psychologist;
- standard school psychologist;
- standard counselor;
- Child Development Specialist with Master's Degree;
- Standard Handicapped Learner Endorsement I or II with Master's Degree; or
- other licensed or certified medical practitioners.

The payment rate for this code includes the case management and supervision functions and necessary supplies for these services.

RS 112 Screening, Testing, Evaluation

Maximum limited to 144 units per year.

Reimbursable time is:

- Student-practitioner interactive services;
- Student observation by qualified staff; and
- Preparation of the written evaluation/testing reports.

These services will be reimbursed only when provided by a licensed or certified practitioner as listed under RS 110, within the scope of their licensure.

RS 114 Nursing Services

Maximum limited to 264 units per month.

Services will be provided by an RN, LPN, or Nurse Practitioner within the scope of their licensure. Services under this code would be:

- Development, assessment and/or coordination of the treatment plan; or
- Direct nursing care services; or
- Training and oversight of any health care aides performing delegated nursing services; or
- Other services within the scope of nursing care.

This code is not intended to reimburse nursing activities of a Private Duty RN or LPN that is otherwise billing OMAP for those services.

RS 116 Delegated Health Care Aide or Transportation Attendant

Maximum limited to 352 units per month.

This code reimburses health care delegated to a health care aide trained to meet the specific requirements of the student's individual plan within the professional standards for that care. Allowable services are:

- Accompanying students that cannot be transported safely without an additional attendant for behavioral or physical reasons; or
- Delegated nursing services as allowed under the Oregon State Board of Nursing published Standards for Registered Nurse Teaching and Delegation to Unlicensed Persons (OAR 851-45-011).

(The child's individual plan must document the need for the transportation aide.)

A unit equals 15 minutes of service.

RS 118 Medical Transportation Mileage/Transportation - School-Based Health Services

Units are equal to the number of miles.

This service is covered only for the miles from student pickup to student drop-off as required in the IEP or IFSP to obtain Medicaid covered related services. Medicaid related services are: speech therapy, physical therapy, occupational therapy, psychological, and/or nursing services. Transportation for education purposes only is not covered by OMAP.

For on-going transportation mileage, transportation must be needed because of the child's disability. The "Related Services" for which the child is being transported must be linked to the child's disability and clearly stated on the IEP or IFSP. For example, the "related" service (i.e., Physical Therapy) is identified on the child's IEP or IFSP and is treatment for the child's disability (Orthopedically Impaired). If transportation is not identified on the IEP or IFSP as a "related service" and the IEP or IFSP does not indicate the covered service to which the transport is needed, the school medical provider cannot bill for the transportation mileage to on-going services.

The provider may bill for the transportation for a Medicaid covered evaluation service. Transportation to an evaluation service is covered, regardless of whether or not an IEP or IFSP is established.

Transportation is not reimbursable by OMAP when provided by the parent or relative of the child.

RS 120 Contracted Consult Service

Each daily service equals one unit regardless of time involved.

Maximum units are limited to 24 per year.

This procedure code reimburses schools for furnishing consultations to IEP or IFSP students for the purpose of evaluation or testing from licensed medical professionals other than provider staff. This service may be on a contracted basis for a number of students. Allowable services must be furnished through a personal service contract between the School Medical provider and the licensed practitioner. This service would only be billed to OMAP when the licensed practitioner did not bill OMAP directly under other programs for the same services.

Accounting, Recordkeeping and Audits

410-133-320 Recordkeeping Requirements

Providers will retain information to document the level of service provided to the child as billed to OMAP for five years. The student health record will include:

- A copy of the child's IEP or IFSP or similar special education plan as well as any addendum to the plan
- A notation of the diagnosis and/or condition being treated or evaluated
- Results of analysis of any health/medical screenings, evaluations, and/or tests
- A description of the duration and extent of each service or intervention activity given, by the date of service
- The record of who performed the service and their credentials or position
- The medical recommendation to support the service.

410-133-340 Client Rights of Record Confidentiality

Providers are required to provide OMAP access to client medical records when requested as a condition of accepting Medicaid reimbursement. Client rights of confidentiality are respected in accordance with the provisions of 42 CFR Part 431, Subpart F and ORS 411.320.

Addendum

Introduction

Since 1975, all children in the nation, no matter what their special education needs, are entitled to a "free appropriate public education." Any health/medical therapy that is considered related to their educational needs must be provided by the school. Special education is defined by federal and state law and includes therapies which also fall under health and medical definitions, and are treatments given by medical professionals.

Recent legislation and court decisions entitle school systems to reimbursement for health care services. The opportunity for reimbursement exists even when health care services are provided under a disabled student's Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP). School systems can seek noneducational sources, including public medical assistance or private insurance for funding services such as speech, psychological, occupational/physical therapy, health related assessments, nursing, or transportation mileage.

While the school systems are financially responsible for educational services, in the case of a Medicaid eligible disabled child, the State Medicaid Agency has a responsibility for paying for the "related services" identified in the child's IEP or IFSP if they are covered under the State's Medicaid Plan.

Schools have been giving student special education services since 1975 when Congress passed the Education for the Handicapped Act, known as Public Law 94-142. P.L. 94-142 requires public schools to identify and serve students who need health-related services so they can benefit from their education. These services are known as special education health-related services.

PL 94-142 (Individuals with Disability Education Act IDEA - 1990), along with PL 99-457, provided the foundation for the Oregon Department of Education (ODE) and the Oregon Medical Assistance Program (OMAP) to undertake a plan, supported by an interagency agreement and HCFA approval, to develop a new way for charging Medicaid for health related services. Medically health related services continue to be provided by local public schools and programs in a "free and appropriate" manner as required by PL 94-142 and state law. Education regulations hold schools to a requirement of informed parental consent before billing any third party payor. Upon approval, the schools bill OMAP. There is no change in Medicaid coverage for lack of, or refusal of consent.

In 1991, OMAP requested a State Plan amendment which added School-Based health services to the list of covered Medicaid services. This model is also referred to as the Rehabilitative Services Option. Not only was this intended to improve the ease of billing, it allows for a much larger array of reimbursable medically-related IFSP/IEP services.

Oregon has been granted a federal waiver that exempts school medical (SM) providers from billing each students private insurer for medical services based on the low percentage of any reimbursement from private insuring resources. This exemption is granted through October of 1996.

Legal Basis for Medicaid Reimbursement for "Related" Services

Education of the Handicapped Act (P.L. 94-142)

When P.L. 94-142 was passed with language addressing the Individualized Education Program (IEP) and designating related services to be offered to handicapped children by the local school system, Congress failed to make clear whether this meant all fiscal responsibility as well as all implementation responsibility. Because this was not clear, many noneducational state agencies interpreted the "free and appropriate" phrase to mean that any services appearing on IEP's were indeed the fiscal responsibility of the school district. Education agencies, on the other hand, were told that they would receive federal dollars to help offset these costs.

The reality of the situation, however, is that Congress has never met its obligation to provide an appropriate funding level of P.L. 94-142. Some of the additional services that school districts are now being forced to offer have previously been the fiscal responsibility of the health care industry. Many educators see no reason to assume fiscal responsibility for these services. Such services as physical therapy, speech-language pathology and occupational therapy are medical services, not education in the traditional sense. The cost for these services should be shared with the health care industry. Because the federal funding levels were not being met and local school districts could not continue to afford all the additional costs, congressional leaders have been confronted with demands to clarify further the original intent of P.L. 94-142.

Bowen v. Massachusetts

In May 1980, the Massachusetts Health Care Financing Administration's Department Grant Appeals Board ruled that certain services to residents of state-owned Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) were not reimbursable under Medicaid. Disagreeing with this decision, the State of Massachusetts requested a review in federal district court.

The Massachusetts Federal District Court handed down its decision in August 1985. The court found that the types of services provided to ICF/MR residents fell within the category of habilitative services and therefore were reimbursable under the Medicaid program. The court was very specific in its decision but Massachusetts viewed it as a victory. The case was appealed by the federal government to the U.S. Court of Appeals for the First Circuit. The U.S. Court of Appeals for the First Circuit affirmed the decision of the district court in May, 1987.

General Accounting Office Report

In June 1985, the Chairman of the House Subcommittee on Select Education asked the General Accounting Office (GAO) to examine the problem of funding for related services. The GAO issued a report one year later making four recommendations based on their finding:[1]

- Amend EHA to state that nothing in the statute should be construed to limit any public health or human services agency from financing some portion of the cost of those services.
- Amend EHA to include in state eligibility requirements the goal of developing interagency agreements to define the financial responsibility of each agency.
- Amend EHA to require states to include in their state plans assurances that such interagency agreements would be encouraged.
- Amend the federal Medicaid program of the Social Security Act, Title XIX to permit Medicaid funds to be spent for educationally related health services for handicapped children as well as nonhandicapped children without regard to their inclusion in an IEP.

Education of the Handicapped Amendment 1986 (P.L. 99-457)

Congress took into account the recommendations made by the GAO and took steps to assure that state and local education agencies would not be required to bear all the financial burden for services that were covered by other agencies prior to the enactment of P.L. 94-142. Included in the Education of the Handicapped Amendments 1986, P.L. 99-457, are clarifying amendments to EHA, Part B and more directive language to states regarding where the financial burden was to fall.

The areas covered by P.L. 99-457 include:

- State Plans reflecting interagency agreements.
- Specifications by State Education Agencies that make it clear that other agencies are not to allow the policies of P.L. 99-457 to relieve them of paying for part or all of certain services required by an IEP.
- Assurance that P.L. 94-142 funds will not be used to satisfy a financial commitment for services that would have been paid for by health agencies.
- This law has become known as the Individuals with Disabilities Education Act.

The Medicare Catastrophic Coverage Act (P.L. 100-360)

On July 1, 1988 President Reagan signed into law P.L. 100-360, The Medicare Catastrophic Coverage Act. The main thrust of this legislation is Medicare, but it contains a significant amendment to the Social Security Act relating to the financing of related services included in a child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). This amendment indicates that Medicaid cannot use the fact of services being required by a child's IEP or IFSP to restrict or prohibit reimbursement for those services.

The section in federal Medicaid law relating to education states:

[1] These recommendations as well as Bowen v. Mass. were covered in depth in the October 30, 1987 ediction of the NASDSE Liason Bulleting, Volume 12, Number 12.

Treatment of Educationally Related Services

(a) Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (b) the following new subsection:

"(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child's individualized education program established pursuant to Part B of the Education of the Handicapped Act or furnished to a handicapped infant or toddler because such services are included in the child's individualized family service plan adopted pursuant to Part H of such Act."

The Conference Committee Report explains the purpose of the amendment:

The conference amendment clarifies that Federal Medicaid matching funds are available for the cost of health services, covered under a state's Medicaid plan, that are furnished to a handicapped child or to a handicapped infant or toddler, even though such services are included in the child's individualized education program or individualized family service plan. Under the Education for All Handicapped Children Act of 1975, P.L. 94-142, children with handicaps are entitled to a free and appropriate public education in conformity with an individualized education program or individualized family service plan. Under the Education for All Handicapped Children Act of 1975, P.L. 94-142, children with handicaps are entitled to a free and appropriate public education in conformity with an individualized education program (IEP) which describes the educational and "related services" necessary to meet the child's unique needs. While the State education agencies are financially responsible for educational services, in the case of a Medicaid-eligible handicapped child, State Medicaid agencies remain responsible for the "related services" identified in the child's IEP if they are covered under the State's Medicaid plan, such as speech pathology and audiology therapy, medical counseling, and services for diagnostic and evaluation purposes.

Regulations have only recently been proposed by the Health Care Financing Administration (HCFA). The new proposed regulations (Volume 55, Federal Register, February 21, 1990, pages 6015-6018), pertain specifically to intermediate care facilities for the mentally retarded (ICF/MR). According to HCFA, the new rules "revise and clarify the meaning of the prohibition against the use of Federal financial participation (FFP) for vocational training and education activities in ICFs/MR) . . ." HCFA's background review of the issue describes the reasons for the previous regulations, e.g., the fact that the Medicaid program is fundamentally a medical assistance program and a payer of the last resort. HCFA cites the following as reasons for developing new instructions for the 1984 State Medicaid Manual:

1. Questions concerning decisions by the Departmental Appeals Board
2. Audit activities by the Office of Inspector General

HCFA's philosophy in 1984 was that ". . . all services required under State and Federal Education laws were excluded

from Medicaid reimbursement because these services are the responsibility of the State." HCFA has since revised its policy because of Bowen v. Massachusetts U.S. 108 S. Ct. 2722 (1988). The Supreme Court upheld the 1985 Massachusetts district court opinion that determination of whether a service is educational should rest on the nature of the service and not the State's method of administering the service. P.L. 99-457, the Education for all Handicapped Children Act Amendments of 1986, caused HCFA further thought. The Act said that funds from P.L. 94-142 would not be used to satisfy financial commitments of other governmental agencies. The last reason for HCFA's movement was section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). According to HCFA, the intent of the amendment was " . . . to ensure that services that would ordinarily be provided or paid for by other agencies for handicapped children would be continued."

The new regulations proposed by HCFA would cover services "that are medical or remedial in nature." HCFA would specify that formal educational services are those relating to training in traditional academic subjects. Subject matter rather than setting, time of day, or class size determines whether a service is education.

Covered Services by Procedure Codes (Additional Information)

School-Based Health services for special education students may be diagnostic, evaluative, or rehabilitative in nature, and must be based on a child's medical needs. These services must be:

1. Identified as eligible for Special Education services by the Multidisciplinary Team (MDT).
2. Services are identified as necessary in the child's Individualized Education Program (IEP) or Individualized Family Services Plan (IFSP), by the IEP/IFSP team.

On-going (RS110) health-related treatment services (individual and/or group) required by a child's Individual Education Plan (IEP) or similar Plan. Services are described in the goals and objectives on the IEP. Services provided are direct and indirect services related to the disability specific to the qualified medical service provider's profession. Direct means face-to-face or "hands-on" therapy. Indirect means phone call conferencing to family members, physician, other service providers, school personnel, documentation time, writing treatment plans, and/or participation in MDT or IEP meetings.

Billing for ongoing health related services is allowed when all of the following have been met:

1. The student has been found eligible under IDEA and is also eligible for Medicaid funding;
2. The ongoing services address a documented medical, health or psychological need;
3. The services have been determined by an IEP team;
4. The services are described in goals and/or objectives on the IEP, and/or modifications and adaptations that support IEP goals and objectives; and
5. The service provider is qualified and holds one of the credentials indicated in OAR 410-133-120.

Screening, Testing and Evaluation (RS 112) services necessary to determine a child's participation in an individualized special education plan (includes screening, meeting time MDT or IEP) specific to the suspected disability is covered, regardless of the results (e.g. non-eligibility). This includes review of health or medical records; phone consultation with family members, school personnel, physician, health care providers, service providers affiliated with the School Provider through direct or contracted employment; and writing of the evaluation report. OMAP will pay for a screen, testing, and/or evaluation that is related to determining initial and three year eligibility for IDEA (special education services) for any student determined eligible for Medicaid funding. Further testing, and evaluation for a student who is eligible for IDEA but is suspected to have additional disabilities under the IDEA is also covered.

Nursing Services (RS 114). For some nursing services, a nursing plan or protocol may be established as part of the IEP. To bill Medicaid, Nursing service(s) must be identified on the IEP as a related service, with treatment protocols defining specific activities or objectives where appropriate. Goals and objectives may not be appropriate

for a nursing plan, however, the plan must clearly state what the nursing procedure/intervention is for, the date of initiation, frequency, duration and projected end of service. Additionally, a medical diagnosis and physician statement/prescription must be obtained for some invasive nursing procedures. The nurse may also provide a nursing diagnosis or functional diagnosis related to his/her findings and recommendations outlined in the Nursing Evaluation or protocol.

Delegated Health Care (RS 116) services can be billed under the authority of OSBN delegation rules (OAR 851-45-011). Delegation by the RN requires 1-1 training and is student specific.

Transportation (RS 118). When billing for transportation mileage on an ongoing basis, the following conditions must be met: A) The student receives transportation as a related service and the destination is to a medical service covered under the Title XIX program. B) Both the transportation and the Medicaid covered service are included in the child's IEP/IFSP. On any day that the above conditions are met, Medicaid payment for transportation to and from school is billable. **(Transportation is billable only on the days medical services are provided.)**

Transportation to an evaluation service is covered as long as the purpose of the evaluation is to determine or redetermine IDEA eligibility and the evaluation is a Title XIX service (e.g. to Podiatrist Services) **and the provider meets licensing standards necessary to be an eligible Medicaid provider. Enrolled LEA's may also bill for transportation to an IFSP Medicaid service, and documentation of the medical service must be available for audit purposes.**

Low-Incidence Regional Programs enrolled as School Medical Providers may bill for ongoing IEP and IFSP health-related services. Regional Programs provide support services to LEA's responsible for children ages 5-21 and support to Early Intervention/Early Childhood Special Education providers responsible for children ages 0-5. Enrolled LEA's responsible for providing transportation and evaluation services (for determining eligibility for IDEA) may bill for students 0-21 years of age. Transportation mileage may be billed for students on an IFSP as defined in the School-Based Health Services Guide.

Mental Health evaluations and services as defined within this handbook are covered services.

School-Based Mental Health Services:

410-133-120, 3(c) Medically Qualified Staff:

> "Psychological evaluations, testing, psychological services and/or treatments shall be provided by individuals who meet the relevant requirements of the Teacher Standards and Practices Commission and/or professional state licensure. Individuals who meet those requirements include: Basic School Psychologist (584-44-014), Standard School Psychologist (584-44-023), Standard Counselor (584-44-023), Child Development Specialist with Master's Degree (584-23-050), Standard Handicapped Learner Endorsement I or II with Master's Degree (584-40-260; 584-40-265), licensed physician, licensed psychologist, licensed psychiatrist, licensed clinical social worker, and licensed counselor."

Psychological evaluations, testing, psychological services and/or treatments shall be provided by individuals who meet the relevant requirements of the Teacher Standards and Practices Commission and/or professional state licensure. Individuals who meet those requirements include: Basic School Psychologist (584-44-014), Standard School Psychologist (584-44-023) licensed physician, licensed psychologist, licensed psychiatrist, licensed clinical social worker, and licensed counselor. In addition the following individuals: Standard Counselor (584-44-023), Child Development Specialist with Master's Degree (581-23-050, and Standard Handicapped Learner Endorsement with Master's Degree (584-40-265) who meet the relevant requirements of the Teacher Standards and Practices Commission as well as the following requirements:

The School-Based Mental Health Provider is otherwise qualified and holds one of the credentials indicated in the School-Based Service Guide (OAR 410-133-120), and:

- has two year postgraduate school-based experience related to children with mental health diagnoses, and
- whose experience is documented by transcripts or letter from supervisor.

Mental Health Evaluations (Assesments, Testing, Screening) and Mental Health Services

Assessments (RS 112)

The use of formal tests of intelligence or personality (e.g., WISC-3, Woodcock-Johnson, Part I, Achenbach, etc.) are billable, regardless of the suspected disability, as long as the following conditions are met:

- Assessments are designed to determine a health related need;
- Assessments are designed to determine eligibility under IDEA;
- The assessments yield a diagnostic report;
- The assessments are within the training and scope of practice for that professional;
- The evaluator is otherwise qualified and holds one of the credentials indicated in OAR 410-133-120.

Additionally, the time spent to conduct the following procedures, which are related to determining eligibility for the suspected disability, are billable and include:

- gathering family, social or medical histories;
- conferring with parents/guardians, teachers and administrators, and/or health care providers (MD's and nurse);
- file reviews;
- formal observations;
- the administration of other tests such as adaptive behavior scales required to determine a student's disability;
- incorporating the results of the tests into reports;
- participation in an IEP or MDT meeting.

Exception: Academic testing, regardless of the suspected disability, is not a billable service.

Mental Health Services (RS 110)

Billing for on-going mental health (RS110) services is allowed when the following conditions have been met:

- The student has been found eligible under IDEA;
- The ongoing services address a documented mental health or psychological need;
- The services have been determined by an IEP team;
- The services address a documented mental health or psychological need and are described in goals and/or objectives on the IEP; and
- The service provider is qualified and holds one of the credentials indicated in OAR 410-133-120.

For anyone whose primary assignment is classroom instruction, she/he may not bill for crisis intervention or on-going behavior management instruction which is delivered within the classroom setting. However, when a child is removed from the classroom setting, billing is acceptable for group/individual counseling as defined by the IEP.

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The following are definitions of billable ongoing services under the School-Based Program, which are supported by IEP goals and objectives, substantiated by psychological evaluations and administered by a qualified provider, within the scope and practice of their licensure:

A. Counseling/Social Work Services - The planned treatment of a student's mental health problems as identified in the IEP.

   The intended outcome from such individual psychotherapeutic services is the management, reduction or resolution of the identified mental health problems, thereby allowing the student to function more independently and competently in daily life.

B. Consultations - Professional input given concerning a specific eligible student provided to others involved in the mental health treatment process, including staff members, school personnel, staff of human service agencies (Adult and Family Services Division, Children's Services Division/State Office of Services for Children and Families, Mental Health, Juvenile Department) or significant others involved in the student's treatment process. Consultation may occur via phone or in person.

C. Group Counseling Services - The planned treatment of a student's mental health problem as identified in the IEP.

Not Covered Related Services

Following are examples of situations where OMAP will not reimburse for school medical services as reflected by rule 410-133-200:

- Transportation to recreational activities or vocational activities, even if prescribed by a doctor or identified on an IFSP or IEP.
- Transportation to sites when the student is not present (illness).
- Transportation to a non-covered Title XIX service. (e.g., plastic surgery).
- Transportation by a relative or family member.
- Medical care not related to the child's Individualized Education Plan.
- Durable medical equipment and supplies.
- Usual and customary nursing services for students who become ill and/or injured in the school or home setting.
- Nursing education provided by nurses to students or staff (e.g., hygiene, first aid classes) etc., and general health counseling.
- Travel time by service provider(s).
- Educational workshops, or training classes to enhance skills.
- Supervision from medically qualified staff with the exception of supervision of RN or Nurse Practitioner to the delegated health care aide or transportation attendant.
- Parent training.
- Family therapy.
- Recreation, vocational services.
- Screenings, assessments, evaluations unrelated to the process for determining or redetermining eligibility under IDEA.
- Education entities (e.g. ESD's, LEA's, or Regional Programs) that contract for all of their service providers.
- Consultation(s) unless tied into the provision of direct services and identified on the IEP through goals and objectives.
- The student was not eligible for Medicaid funding on the date of service.

ICD-9 Diagnosis Requirement and Oregon Health Plan Phase II

As an enrolled provider with the Office of Medical Assistance Programs (OMAP) you should have received information on the Oregon Health Plan (OHP) such as the Administrative Rules and other changes to comply with Medicaid. OMAP administers the Medicaid portion of the Oregon Health Plan as one program of Oregon's Title XIX State Plan.

The medical community by law has been required to provide ICD-9 coding for reimbursement since 1988. With the OHP, all providers are required to provide this coding. We are aware that the medical world requirements may present some unique challenges to schools; therefore, to help you meet this requirement to use ICD-9 codes, a guide is enclosed that identifies the discipline, the medical diagnosis as established by the licensed health care provider, and the corresponding identifying code, including signs and symptoms for evaluations, as well as sample physician statement (where applicable). For IDEA eligibility which requires a physician statement, you may wish to add a space, on the statement, for the physician to provide a primary diagnosis.

To meet the Federal and State Medicaid requirements you must use the ICD-9 diagnosis codes to the 4th or 5th digits, where applicable, on HCFA claim forms for all services for which you are seeking Medicaid reimbursement.

For evaluation services, the licensed health care provider, within the scope and practice of their licensure, may use presenting signs or symptoms to determine ICD-9 codes. e.g.: Audiology - Unspecified hearing loss.

To successfully bill OMAP for claims under the Oregon Health Plan, you need to use the complete ICD-9 code. OMAP requires use of all digits of the ICD-9 code (i.e., if the code has four digits, your claim must include all four digits). Otherwise, your claim will be denied. The *ICD-9-CM* book includes instructions for finding the correct code. Include only the diagnosis specific to that claim. Also, your biller must use the most recent version of the *International Classification of Diseases*, Ninth Revision, fourth Edition, October 1993 (ICD-9-CM). School Medical providers can purchase Volume I (Index) and Volume II (the body) through the Government Store, 1305 SW First Avenue, Portland, Oregon 97201, (503) 221-6217 (Hours: 8:30 - 4:00). The price is $65.00 for the base manual. Codes from earlier versions may not be adequate and could cause your claim to be rejected.

Due to the difficulty in ascertaining a medical diagnosis for the SED child, it is recommended that the ICD-9 codes correspond with signs and symptoms or use the V79.9 or 783.4 codes. A list of diagnoses by profession (identified by the practitioner) is included to assist you in meeting this requirement. It is possible that some ICD-9 diagnosis codes may be served by more than one discipline. (i.e., Occupational Therapy: Mental Retardation - 318.0; Speech Therapy: Mental Retardation 318.0) or that the claim could have more than one diagnosis, depending on the treatment provided (i.e., Occupational Therapy: Cerebral Palsy 343.9; Speech Therapy: Development Articulation Disorder 315.39; both of which are billed under code RS 110 Basic Treatment Services). However, to get your claim processed, you may use only one primary

diagnosis. Medicaid will look for a complete diagnosis and reads only the first numeral diagnosis for determining if it falls above or below the line on the OHP list. You will continue to require your individual service providers to indicate ICD-9 codes for the disability condition they are treating or providing service. These individual diagnoses should be retained on file to be available for auditors.

OMAP's claims system will only accept school medical claims with ICD-9 diagnosis. This applies to all procedure codes. In addition, to meet the requirements of the OHP, your claims will be run against the prioritized list. This means the ICD-9 diagnosis must match a diagnosis that falls within the criteria established by the OHP (See your OHP Administrative Rules provider guide for ICD-9 Diagnosis Codes.) The Addendum contained in this guide is not all-inclusive; it is meant to be used as a reference. All the codes listed currently meet the criteria (or are above the OHP line) however, if a code is not applicable to the disability, you will either need to look further to obtain a primary diagnosis or use the diagnosis even if it is not on the list.

If you have questions about a diagnosis code eligibility, call the Medicaid Benefit RN Hotline, toll-free at 1-800-393-9855

Schools enrolled in the School-Based Health Services program will continue to submit claims on a fee-for-service basis to OMAP for payment, not to a managed care plan.

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A Guide for ICD-9 Diagnosis Codes for School Personnel per Discipline

Discipline	ICD-9	Medical Diagnosis (Established by licensed health care physician or practitioners within the scope of practicing license.)
Nursing	995.3	Allergies (Severe Allergic Reaction) Bee Sting, Food, Allergen
	493.90	Asthma (Without mention of status)
	493.91	Status Asthmaticus
	343.9*	Cerebral Palsy
	277.01	Cystic Fibrosis, with meconium ileus
	277.00	Cystic Fibrosis, without meconium ileus
	250.01	Diabetes Mellitus, Type I, Insulin Dependent (not stated as uncontrolled)
	250.03	Diabetes Mellitus, Type I, Insulin Dependent, uncontrolled
	359.0 to 359.9	Neuromuscular Dystrophy (Neuromuscular Dysfunction in eating, swallowing, bowel/bladder control)
	V20-V21	Preventative Services (Health screening of child)
	345.10	Seizure Disorder, generalized convulsive (nonintractable)
	345.00	Seizure Disorder, generalized nonconvulsive (nonintractable)
	334.4/V45.2	Hydrocephalus/Shunt
	741.00	Spina Bifida (Myelomeningocele) with hydrocephalus (nonspecified region)
	741.90	Spina Bifida (Myelomeningocele) without mention of hydrocephalus (nonspecified region)
	854.00	Traumatic Brain Injury (TBI), unspecified state of consciousness without mention of open intracranial wound
	854.10	Traumatic Brain Injury (TBI), unspecified state of consciousness with open intracranial wound
	286.4	Von Willebrand's Disease
Physical Therapy	335.20	Amyotrophic Lateral Sclerosis
	343.9	Cerebral Palsy
	754	Congenital Musculoskeletal Deformities

Discipline	ICD-9	(Established by licensed health care physician or practitioners within the scope of practicing license.)
Physical Therapy	781.3	Lack of Coordination (Muscular Incoordination)
	341 to 344	Demyelinating Diseases of CNS
	342.0	Flacid Hemiplegia
	342.1	Spastic Hemiplegia
	344.0	Quadriplegia
	330 to 337	Hereditary and Degenerative Disease of CNS Manifested in Childhood
	340	Multiple Sclerosis
	359.0 to 359.9	Neuromuscular Dystrophy (Neuromuscular dysfunction in posture and movement)
	335.21	Progressive Muscular Atrophy (Duchenne's)
	741.00	Spina Bifida (Myelomeningocele) with hydrocephalus (nonspecified region)
	741.90	Spina Bifida (Myelomeningocele) without mention of hydrocephalus (nonspecified region)
Speech	784.30	Acquired aphasia
	784.3	Aphasia (auditory, classic, expressive, global, motor, receptive, sensory, syntactial, verbal)
	343.9	Cerebral Palsy
	749.00	Cleft Palate (unspecified)
	315.39*	Developmental Articulation Disorder
	315.31 to 315.39	Developmental Language Disorder (Neurological dysfunction in communication) (Retarded Development of Speech)
	758.0*	Down's Syndrome
	307.0	Dysfluency (stammering and stuttering)
	784.69	Dyspraxia
	313.23	Elective Mutism
	348	Encephalopathy
	317.0*	Mental Retardation, Mild (IQ 50-70)
	318.2*	Mental Retardation, Moderate (IQ 35-49)
	318.1*	Mental Retardation, Severe (IQ 20-34)
	359.0 to 359.9	Neuromuscular Dystrophy (Neuromuscular dysfunction in communication)
	784.50	Other speech disturbance - dysarthria, dysphasia

Discipline	ICD-9	(Established by licensed health care physician or practitioners within the scope of practicing license.)
Speech	854.00	Traumatic Brain Injury (TBI), unspecified state of consciousness without mention of open intracranial wound
	854.10	Traumatic Brain Injury (TBI), unspecified state of consciousness with open intracranial wound
	784.49	Voice Disturbance (hoarseness, change in voice/ pitch, hypo/hypernasality)
Occupational Therapy	343.9	Cerebral Palsy
	277.01	Cystic Fibrosis, with meconium ileus
	277.00	Cystic Fibrosis, without meconium ileus
	758.0	Down's Syndrome
	317.0*	Mental Retardation, Mild (IQ 50-70)
	318.0*	Mental Retardation, Moderate (IQ 35-49)
	318.2*	Mental Retardation, Profound (IQ under 20)
	318.1*	Mental Retardation, Severe (IQ 20-34)
	359.0 to 359.9	Neuromuscular Dystrophy (Neuromuscular dysfunction maximize level of independence in self-directed care)
	356 to 357	Peripheral Neuropathy
	V40 to V41	Preventative Services (Problems with special senses)
	741.00	Spina Bifida (Myelomeningocele) with hydrocephalus (nonspecified region)
	741.90	Spina Bifida (Myelomeningocele) without mention of hydrocephalus (nonspecified region)
	854.00	Traumatic Brain Injury (TBI), unspecified state of consciousness without mention of open intracranial wound
	854.10	Traumatic Brain Injury (TBI), unspecified state of consciousness with open intracranial wound
	349.9	Unspecified Disorder of the Nervous System
Mental Health	314.00	Attention Deficit Disorder (ADD)
	314.01	Attention Deficit Disorder with Hyperactivity (ADHD)
	299.00*	Autism, active state
	296.30	Depression (recurrent, unspecified)
	758.0	Down's Syndrome

Discipline	ICD-9	(Established by licensed health care physician or practitioners within the scope of practicing license.)
Mental Health	313.22	Introverted/Social withdrawal of childhood
	317.0*	Mental Retardation, Mild (IQ 50-70)
	318.0*	Mental Retardation, Moderate (IQ 35-49)
	318.2*	Mental Retardation, Profound (IQ under 20)
	318.1*	Mental Retardation, Severe (IQ 20-34)
	313.1	Misery and Unhappiness Disturbance of Emotions
	313.0	Overanxious Disturbance of Emotions
	V79	Preventative Services (Special screening for mental disorder and/or developmental handicap)
	313.21	Shyness/Sensitivity of childhood
	312.00	Undersocialized Disturbance of Conduct (e.g., Aggressive Outburst/Anger Reaction) (unspecified)
	313.9	Unspecified emotional disturbance of childhood or adolescence
Audiology	V72.1	General Hearing Exam
	389.00*	Hearing Loss, Conductive (over 3 years old) (unspecified)
	389.10*	Hearing Loss, Sensorineural (over 3 years old) (unspecified)
	389.2	Mixed conductive and sensorineural hearing loss
	389.9	Unspecified hearing loss
	381.4	Otitis Media, unspecified
Vision	V72.0*	Screening Exam
	369.4	Legal Blindness, as defined in USA
	369.00	Blindness (acquired) (congenital) (both eyes)
	743.30	Congenital cataract (unspecified)
	377.75	Cortical blindness
	367.1	Nearsightedness, myopia
	367.0	Farsightedness, hypermetropia
	367.4	Presbyopia
	367.20	Astigmatism (unspecified)
	368.59	Color vision deficiencies (unspecified)
	368.45	Tunnel Vision
	367.9	Disorder of refraction and accommodation (unspecified)

Discipline	ICD-9	(Established by licensed health care physician or practitioners within the scope of practicing license.)
Evaluation	V79.9*	Screening for mental and/or developmental handicap
	783.4*	Lack of expected normal physiological development (e.g., delayed milestones, failure to thrive, physical retardation)
	V71.02	Dyssocial behavior without manifest psychiatric disorder
	V61.20	Concern about behavior of child and/or parent-child conflict
	V62.3	Educational handicap — Dissatisfaction with school environment, i.e., psychosocial circumstance
	V71.8	Observation and evaluation for specified suspected condition

*Most commonly used diagnosis codes.

Note: Some diagnoses may be served by more than one discipline

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Source: St. Anthony's Color Coded ICD-9-CM Code Book for Physician Payment, Volume 1, 1994 Softbound Edition.

Accessing Medicaid Eligibility for Student Populations

Educational Entities enrolled with OMAP as a School Medical Provider (SM):

Education Service District (ESD, Local Education Agency (LEA) or Regional Program (RP)) can submit requests to determine whether students are eligible for Medical Services through OMAP. Requests should be sent to OMAP on Personal Computer files using the following process.

Send one or more files containing student eligibility requests to OMAP.

- Dial-up the OMAP Host Personal Computer (P/C).
- Log on to the OMAP Bulletin Board System.
- Upload one or more files containing requests to be processed from your local P/C to the Host P/C. You can submit any number of files during the week. The OMAP Host P/C will be available for sending data Monday through Friday, 24 hours per day.

Every weekend, computer processing will be run to determine student eligibility.

- All requests submitted during the week will be merged.
- Each request will be matched against current eligibility information using the data supplied for each student.
- Students will be either medically eligible, potentially eligible or not eligible for services.
- For those students who are medically eligible or potentially eligible, additional information will be captured.
- A single file for each ESD, LEA or RP containing the results of the matching process will be placed on the OMAP Host P/C.

Anytime during the following week, you can retrieve the results of the eligibility matching.

- Dial-up the OMAP Host P/C.
- Log on to the OMAP Bulletin Board System.
- Download the results file from the OMAP P/C to your local P/C.

Note: You may continue to send P/C diskettes to OMAP. However, this process will result in less timely processing due to mail service delivery, manual uploading and downloading of the diskette to the Host P/C by OMAP personnel and packaging and return of the information to your location.

Questions? Contact:
Dennis Garlock at 945-6608.

Documenting Medical/Health Related Evaluation and Treatment Services

Service Provider guidelines in documenting tests, assessments and evaluations:

Minimally, Medicaid needs the following information documented in the student's file:

1. **The date of the evaluation.** If several tests were used over a period of time, all dates should be indicated.
2. **The specific service rendered.** Name the test or processes which make up the evaluation and include copies of the results. Tests should be objective, establish baselines and be usable to plan treatment. Use ordinal or ration scales of measurement (e.g., 0 - 10, or 0 - 5).
3. **Summarization** of collective findings inclusive of any professional service/treatment recommendations.
4. **Place service was provided.**
5. **Name of performing provider.** The name of provider who actually performed the tests should appear to assure that qualified medical professionals actually gave the evaluative service.
6. **The medical diagnosis/ICD-9 code.**
7. **Other.** If testing requires an unusually long time, that should be explained in the documentation. This is helpful information for two reasons:
   a. It can help explain the complexity of the test, and
   b. It provides the next performing provider with an understanding of the student's medical condition.

Evaluations are used by school personnel to determine eligibility for Special Education Services under IDEA. Evaluations play a key role in the IEP/IFSP development or they may determine that a student does not require Special Education Services. Evaluations may also be performed to "rule out" a certain condition or disease.

The *diagnosis* which best states the student's medical condition being treated or diagnosed should be used as the *primary diagnosis.*

Service Provider guidelines for documentation of ongoing treatment services:

You must maintain legible, accurate and complete records in order to support and justify the services you provide. ***Record*** means a data report supporting claims submitted to the Medical Assistance Program for medical services provided. For reimbursement purposes, such records shall be legible and include:

- Date(s) of service.
- Patient's name and date of birth.
- Name and title of person performing the service. This is the service provider.
- Description of treatment.
- Documentation of student progress.

These records must be retained for at least five years.

When completing documentation for Basic School-Based Health Services or Ongoing Treatment (OT, PT, Speech, Mental Health Services), you may want to consider answering the following questions (these are not required for each entry, but for the documentation overall):

- How did the client or student present themselves?
- What type of expertise did you use in providing the service/treatment?
- What exactly did you do?
- What type of specialized medical intervention did you use?
- What was the result of the service/treatment?
- How did the service/treatment provided relate to the student's IEP goals?
- Did you document these things on each date of service/treatment?

Records must be available to OMAP upon request. Documentation must be timely, complete, and consistent. OMAP conducts provider audits in order to determine compliance with the various rules governing its medical programs.

When completing documentation for **Delegated Health Service by an Assistant or Transportation Health Assistant:**

> Documentation for those services needs to include one or two sentences describing the service provided and the medical or safety necessity for the assistant attending the student. And documentation of the training given to delegate the specific task for that student.

Things to avoid in documenting evaluations and ongoing treatment services:

- Subjective statements
- Estimating a student's condition or progress
- Guessing or commenting on a student's mental status
- Overstating tests that were not performed
- Recording services with "ditto" marks

Things to remember in documenting evaluations and ongoing treatment services:

- If a key is used, (abbreviated recording), keep a master copy on file
- Legibility is important
- Each provider should keep student records separately (even if providing services in a group environment)

In addition to the IEP and student log, Medicaid requires school medical providers to provide access for onsite review of a student's records. These documents do not have to be kept in a central location, although many providers do so during a Medicaid review. Some districts maintain a separate Medicaid file with copies of: statement of eligibility, IEP's, student log forms, billing forms, evaluations and, if necessary, physician prescriptions.

During a review, the auditor will look for the following documents:

- licenses, certificates and practitioner qualifications for each service provider (this includes employees and contracted service providers),
- reimbursement rates to School Medical Providers for health related services provided to Medicaid eligible students which are based upon the cost of providing these services,
- cost data analysis reports for services provided to Medicaid eligible special education students,
- documentation indicating whether the services were provided by a licensed/certified practitioner or by persons trained or supervised by a licensed practitioner (e.g., delegated health care aide or transportation attendant.)
- an IEP (including the cover page, goals and objectives) indicating the duration of service,
- statement of eligibility,
- if indicated, a physician prescription/statement
- evaluation reports e.g., screening, nursing protocols,
- billing documentation which:
  - relates to the IEP
  - indicates dates and time services were rendered
  - indicates who provided the services
  - is signed by the service provider
  - indicates place of service
  - describes outcomes e.g., progress or lack of progress

Use discretion and if in doubt, don't bill! To withstand a Medicaid audit, it is very important that your district be able to substantiate the service provided. This means the student has been determined to be eligible for special education and health related services, has an IEP, and a health care professional recommends the service (i.e., Results of a PT evaluation recommends Passive Range of Motion to prevent further deformity/contractures due to spasticity {this is a functional diagnosis}). The ICD-9 diagnosis should also be included.

An acceptable example of a procedure for determining billing costs for Medicaid

Step	Process
1.	Average annual salary + fringe benefits by discipline. This includes: • medical • PERS • FICA/SAFE
2.	Divided by 900 average contact hours. (The 900 average contact hours is determined by OAR 581-22-503 which addresses required instructional time as: 990 hours for grades 9-12; 900 hours for grades 4-8; and 810 for grades 1-3.)
3.	Steps 1 and 2 equal the cost per hour.
4.	Multiply Step 3 by your district's operation costs. Operations costs include: billing clerks, administrative staff, rent, phone, travel, licensure, billing fees (Benova), rent, phone, electric, materials, computers for staff, printing costs.
5.	Completion of Step 4 equals per dollar operation cost.
6.	Add Step 3 and 5. Multiply that sum by your district's approved indirect rate.
7.	This figure equals the per dollar indirect rate.
8.	Add Steps 3, 5 and 7 to determine your district's total cost per hour.

Medicaid Questions and Answers

History

Q. Is Oregon the only state in which districts are billing Medicaid or private insurance?

A. No. Presently more than 38 other states are either billing or making plans to develop a school billing program.

Q. Why are schools now entitled to bill third parties?

A. With education and medical costs going up, states have felt a great financial burden in providing quality education. Funding the related medical and health services is an added financial responsibility. Congress responded to state education agencies' needs by requiring that other state agencies help fund certain services. (Education for the Handicapped Act, 1986 Amendment)

Public insurers such as Medicaid and private insurers may be billed for health screenings and assessments, and for services described within a student's IEP or for other medically necessary services. Very few private insurers cover IEP health services.

Q. Whom does the School-Based Health Services help?

A. All children will benefit either directly or indirectly from the revenues related to health care services in our schools. The purpose of the School-Based Services program is to ultimately better serve children - contributing to the child's education by utilizing public health resources (Medicaid) for health care services.

Q. Who pays for these services?

A. These services are given free to all students who need them. In Oregon, they are primarily funded by local tax dollars. The federal government pays less than 9 percent of the cost of special education, and the state General Fund pays 70-80 percent, leaving the remaining 20-30 percent to be paid from local property tax efforts.

With school budgets stretched to the limits, with more children with disabilities in the school system, and with ever-increasing costs of providing the more complex medical and health-related services, schools are desperate for any private or federal relief that may be available. Billing Medicaid is one way for local schools to recover federal dollars for these federally mandated services. In Oregon, approximately 18 to 24 percent of the handicapped student population is covered by Medicaid. The Federal portion of the Medicaid reimbursed service is 62 percent. The General Fund portion for the match is 38 percent. **The percent is determined by a per capita formula and changes every October 1.** The reimbursement is deducted by ODE as an allocation to districts who are billing and receiving Medicaid payments.

Medicaid Payments - Federal/State Dollars

Date	Federal Dollars	State Dollars
10/01/94 - 09/30/95	62.36	37.88

General

Q. Can EI/ECSE IFSP services be billed?

A. Local school districts assuming responsibility for transportation and evaluation services related to an IFSP, may bill under the School-Based Health Services program. Low-Incidence Regional Services programs may bill for ongoing IFSP services under the School-Based Health Services program. EI providers are not allowed to bill for services.

Q. Will services provided by any school therapist be reimbursed by Medicaid?

A. No. Medicaid requires that service providers have appropriate licensure through the Oregon State Licensing Board and/or certification through Oregon Teacher Standards and Practices Commission. Please refer to the rules in the "School-Based Health Services Guide" concerning medically qualified service providers.

Q. Will I have to change the service I provide students in order to bill?

A. No. If any portion of the service that you provide is not eligible for reimbursement, it will not be billed. Providers must continue to provide the services determined to be appropriate according to each student's Individual Education Program, and in some cases the, Individual Family Service Plan. The billing process does not change or have any effect on the existing district IEP protocols. Billing should not change those students who are identified for service, the level of services to be provided, nor the individual service provider who delivers the service.

Q. Who gets the money that is generated by insurance billing?

A. All federal funds generated through the billing process go to the district, ESD or Regional Program.

Q. Are physician prescriptions or referrals required?

A. Physician prescriptions or referrals are required by state law for some nursing services as identified in nursing scope of practice rules.

Q. Has the emphasis on "educational" services shifted to "medical" services in schools?

A. Definitely not. The responsibility of the school district is to provide educational services. Certain health care services are necessary for some special education students to attend school and receive educational benefits. Requesting reimbursement for those services meeting the medical definition for coverage is a funding action, not a shift in service emphasis.

Q. Can a school medical provider contract with individuals and/or organizations to provide related services and be reimbursed for those services?

A. While the education entity should hold primary responsibility for providing these services with it's own qualified staff, it may also contract, on a supplemental basis only, for covered services with individuals or organizations that meet qualifications

for medical staff as outlined in Rule 410-133-120. An education entity that contracts for all of its service providers is **not eligible** to be a School-Based provider and bill Medicaid under the School-Based Health Services program.

Q. Can a district, ESD or Regional Program bill for a School Medical Provider (LEA, ESD, Regional Program)?

A. Yes. A "billing" provider essentially is an address to which payment for Medicaid service is sent. The billing provider may represent a group of performing providers or it may be a billing address for a single performing provider. An individual school must obtain a school medical provider number regardless of another entity billing on it's behalf.

If a school entity is to be a billing provider, a performing school-based provider must provide the service and the billing to Medicaid must reflect both provider numbers in the appropriate field on the claim.

The Medical Assistance Program will make payment only to the enrolled provider of the services or enrolled billing provider for covered services rendered to eligible clients.

Technical

Category: Screenings

Q. Can the district bill for a hearing and speech screening?

A. Yes. If the screening is designed to identify children who may require more intensive assessments/evaluations or where the diagnosis may lead to the determination of IDEA eligibility.

Q. How are screening results documented?

A. Acceptable paperwork/documentation would be the following:

- a description of the service type/purpose (e.g., hearing screening),
- the date the screen was done,
- service provider (name, title, signature),
- amount of time it took to complete the screening,
- the name of the student, and
- record of the results of the screen.

Q. What screening activities are considered to be "billable"?

A. Billable activities would include the following:

- time spent in preparation,
- time of the actual procedure, and
- time spent documenting the results/findings.

Q. How do you establish a reasonable reimbursement rate for screenings?

A. If you have several students who are to be screened, it is recommended you look at the average time it takes to do a complete screen from start to finish. Bill according to the average minutes spent. If the screen takes five minutes, then you would bill for one unit of time, at a rate adjusted to reflect the actual minutes, not for the full 15 minutes or unit of time. If a screen requiring 15 minutes (1 unit) is billed at $15.00, you would bill for $5.00 for five minutes.

It is necessary to document how you established rates for the screening(s).

Q. Can the service provider bill for the time spent researching students' names, eligibility status, etc., to prepare for hearing and speech screenings?

A. No. That time has already been figured into the payment rates.

Q. How often are evaluation or status reports needed and to whom does the report need to go? Physician? Medicaid office? Both?

A. Reports, etc., do not have to be submitted to the Medicaid program under the School-Based Health Services program. Evaluation reports need to be conducted following IDEA guidelines and should be accessible for audit purposes.

Q. Do reports have to be submitted to OMAP?

A. No. Covered services do not require prior authorization, but they must be retained by the district and available for audit. Medicaid views the IEP as the document that authorizes payment for services. The IEP must be current and have treatment goals related to the service that is billed. Billed services must reflect the IEP date (start and end of IEP).

Q. Who can recommend services?

A. Requests for payment of medical services required by a child's IEP must be supported by written documentation of a licensed medical practitioner recommending the services. (This is often reflected in the Evaluation Report(s), e.g., speech and language evaluation). The recommendation must be updated annually. This can be accomplished at the Annual IEP Review.

Example: Speech services must be recommended by:

- A person who has been granted a Certificate of Clinical Competence by the American Speech, Language and Hearing Association; or
- A person who is State Board licensed as a Speech Pathologist.

For documenting therapy recommendations from speech therapists the child's record should include a statement such as: "Recommended by the speech therapist and in agreement with the MDT eligibility meeting, IEP, or IFSP."

Q. Does a form need to be developed for evaluation results or will the IEP be sufficient?

A. An IEP is not sufficient. Evaluation results always need to be documented. It is not enough to have the actual test – results must be clearly described by the service provider/practitioner.

Q. Is clerical support time needed to process claims forms billable?

A. No. However, clerical support is a separate administrative activity and can be included when calculating the hourly cost per provider. (See "Calculate Cost" for establishing rates.)

Q. Can the service provider bill for staff time spent in the MDT meetings?

A. Yes, if the MDT meeting is to determine a student's eligibility for special education, the provider could bill for the time spent in addressing the suspected disability, under the scope and practice of their licensure.

Q. If a qualified provider received an assessment referral, and as such was assessing a student for academic reasons (i.e., reading) but discovers the child has a speech impairment or behavioral problems, may the qualified provider bill for the additional time spent in addressing those issues?

A. No. The "qualified provider" is functioning as the classroom teacher. Therefore, the teacher would not bill for the time spent addressing the speech or behavioral issue because it is not within the scope and practice of their licensure.

Q. Can I bill for the time spent to prepare the written MDT report/summary?

A. No.

Q. What if the child being assessed does not qualify for special education and an IEP is not written, can we still bill for the assessment?

A. Yes.

Category: General Information

Q. Are activities such as phone calls, team meetings, chart reviews, and manipulative device construction billable?

A. Yes. They are considered an integral part of providing basic treatment services.

Q. If a medical provider is serving three Medicaid IEP students in a group, how much time can the provider bill per student?

A. Each student's IEP will be individualized to reflect the therapy goals, frequency and duration of service; e.g., three times weekly, 30 minute sessions, per student. You should bill for the amount of time you spent with each student. Your reimbursement rate for group therapy should be prorated - in other words, the amount (rate) should be lower than an individual therapy rate.

Q. Is a service billable when additional time for the treatment is specified on the IEP under the characteristics of service?

A. Yes. (e.g., "a student receives physical therapy one time per week for 30 minutes, but occasionally needs an extra session to teach a new skill, but will receive an extra session when skills fall below a specified level.")

Q Is communication with parents, educational staff, or other professionals, which is related to the IEP, billable?

A. Yes, as long as it relates to the specific goals and objectives on the IEP.

Q. Does a physician's prescription for any treatment or service mean that the service is covered under the School-Based Health Services Program?

A. No.

Q. Does direct therapy include activities such as the fabricating or adapting of positioning equipment, appliances or technology devices?

A. Yes. Under RS110 if the equipment adaptations are identified on the student's IEP as a related service and are supported by evaluations.

Q. Can we bill for a classroom assistant who provides health care for a student with severe disabilities?

A. Yes, under Medicaid conditions where the classroom assistant was trained as a "delegated health care aide" by a licensed professional (See rule 410-133-300 RS 116). However, time spent by a speech therapy assistant is not billable.

Q. Are repairs, minor adjustments, programming (e.g., communication devices) billable when they are performed by a licensed practitioner under the scope and practice of their licensure?

A. Yes.

Q. At what point does billing for related services become excessive?

A. Billing excessively should not drive the therapy methodology; however, it is wise to consider all therapy for appropriateness to avoid overutilization. Auditors from Medicaid do become concerned when a particular service appears to be inordinate or way above what other like providers are billing.

Q. Must the Physical Therapist obtain a Physician Prescription for PT services?

A. No. Physical therapists must function within the scope of their licensure. In the special education environment, HB 2549 waives the requirement to obtain a physician prescription for IEP related Physical Therapy services.

Q. Can I bill under the School-Based Health Services program for students who are 504 eligible but not eligible under I.D.E.A.?

A. No.

Q. Under what service code (i.e., RS 110 or RS 112) is an observation billed?

A. RS110 - If a child has a current IEP and part of the measurement of progress involves an observation component related to the health service being provided.

RS 112 - If the observation is related to the formal evaluation process (to determine IDEA eligibility and/or additional eligibility or redetermination of IDEA eligibility) and to determine the need for health services.

Q. Under what service code (RS 110 or RS 112) is a conference billed?

A. RS 110 - during an IEP meeting for the purpose of exchanging information for the purpose of planning.

RS 112 - for purposes of sharing information to better assist in the evaluation process.

Q. Under what service code (RS 110 or RS 112) is a consultation billed?

A. RS 110 - If the consultation with other professionals, parents, or teachers is for the purpose of discussing the student's condition and it relates to a specific health related service as identified in the student's IEP.

RS 112 - If the interaction with the other professionals, parents, or teachers is considered relevant for the purpose of assessing a student's health condition.

Category: Recordkeeping/Audit

Q. If a child moves from your district, who needs to keep the billing records?

A. A school medical provider must keep individual billing records for five years.

Q. Does Medicaid require therapy logs to reflect progress toward the outcome indicated in the IEP?

A. Yes. It is recommended that the therapist record progress every 3-4 entries. Progress can be noted using percentages that correspond with the student's IEP. Each time a service is provided, the therapist must record this in the student record.

Q. Does Medicaid require nursing records to reflect student progress?

A. No. However, nurses must document nursing interventions with clients according to their licensing requirements and per the student's IEP (eg., nursing care plan/ protocol).

Q. How long do Medicaid records have to be kept?

A. Five years. If a student leaves the district, copies of relevant records must be retained for Medicaid audit purposes.

Q. How often must the licensed medical practitioner provide written documentation which recommends the health service?

A. The licensed medical practitioner should provide written documentation for the health service through the annual IEP review process and by the evaluation process (may be initial and/or three year).

Category: Examples of Acceptable Documentation

Q. What are some examples of acceptable documentation for oral language therapy?

A. If a student's short term communication goal was: "John will continue to utilize his oral and receptive language skills in the school environment," examples of acceptable documentation might be:

"John worked on stating the relationship between objects, events and concepts."

"Worked with John on using past, present and future tense markers in sentences."

"Conversational skills - beginning and ending conversations appropriately."

Q. What are some examples of acceptable documentation for articulation therapy?

A. If a student's short term articulation goal was: "To increase John's ability to articulate the "r" sound in isolation, phrase and sentences," examples of acceptable documentation might be:

"Had John target the "r" sound by imitating the sound in isolation, syllables and words."

"John practiced using the "r" sound in words, phrases and sentences."

"John practiced using the "r" sound in conversation and reading."

Q. How would you document a student's progress?

A. Documentation of a student's progress could be stated in the following ways:

"Student successfully used four words in three practice sessions."

"Student is maintaining current level of performance without cueing."

"Student has increased accuracy by 60 percent in four out of five trials."

Q. What are some examples of acceptable documentation for occupational therapy?

A. If a student's short term goal was: "To increase mastery of self-help skills which are due to an orthopedic impairment," some examples of acceptable documentation might be:

"Provided 4 hours of direct service by modeling adaptive equipment to student."

"Observed student during lunch. Hand splint needs to be adjusted."

Q. What are some examples of acceptable documentation for physical therapy?

A. If a student's short term goal was: "Student will tolerate a positioning in her prone stander as noted by zero negative responses to weight bearing effect," some examples of acceptable documentation might be:

"Student tolerated positioning for three minutes."

"Assisted student with positioning in prone stander."

"Assisted student with increasing tolerance to prone stander."

Q. What are some examples of acceptable documentation of mental health services?

A. If a student's short term goal was: "To increase student's ability to interact positively in a small group setting," some examples of acceptable documentation might be:

"Assisted student in appropriate methods of sharing toys."

"Mediated play session between student and a friend."

"Worked with student on acceptable methods for requesting objects from other students."

Category: ICD-9 Diagnosis Codes

Q. Where do I obtain an ICD-9 diagnosis?

A. The diagnosis can be obtained by contacting the student's primary care physician, attending physician, or medical practitioner. A complete list of ICD-9 diagnosis may be purchased through the U.S. Government Bookstore #31, 1305 S.W. First Avenue, Portland, Oregon 97201. (503) 221-6217.

Q. Does each service provider need to assign a diagnosis code?

A. Yes. This may be a therapy recommendation for treatment provided by the service provider to which an ICD-9 code can be assigned, i.e., articulation disorder ICD-9 314.31.

Support

Q. How does a district proceed?

A. 1) Find out all you can from other districts who are successfully billing. Some of these are: Portland Public Schools, Salem/Keizer School District, Yamhill ESD, Linn-Benton/Lincoln ESD, Multnomah ESD, Union ESD, Oregon School for the Blind, Oregon School for the Deaf, Central Oregon Regional Program, Northern/Multnomah Regional Program.

2) Investigate the option of the billing process. Districts can opt to manage the billings themselves or they can contract with an electronic transmission service such as Medibill or Benova.

3) Decide which method your district will use to determine which IEP/IFSP students are Medicaid eligible.

Q. How can a district bill?

A. OMAP's Claims Processing System, MMIS (Medicaid Management Information System) accepts both paper and electronic medical claims. Districts can bill OMAP on the HCFA-1500 form which is the standard paper form used by Medicaid and published by the Health Care Financing Administration. A reasonable time for paper claims to process is four weeks.

OR

Districts can bill OMAP directly by submitting claims electronically - over the telephone (through a modem), floppy disk or 3480 cartridge. The advantages of Electronic Billing are: 1) Faster payment (most claims are paid within a week); 2) Fewer errors (claims bypass OMAP's data entry process); 3) Forms/postage (there is no need to fill out forms, put forms in envelopes, and mail forms); 4) priority handling (electronic claims receive priority handling in suspense resolution).

OR

Contract with a professional billing service. Third party billing agents can provide electronic billing services.

Q. Where are the Oregon Administrative Rules (OAR) for billing under the school program?

A. The OAR's are in the first section of the *School-Based Health Services* provider guide. These are used in conjunction with the *General Rules for Oregon Medical Assistance Programs* and the *Administrative Rules for the Oregon Health Plan Medicaid Demonstration Project*.

Forms

State of Oregon
Department of Human Resources
Adult and Family Services Division

Provider's Form Request

Instructions:

1. Fill in the Provider information at right (*press firmly*).
2. Order only those forms listed on this request. HCFA 1500 Billing Forms not available through AFS or OMAP
3. Complete the "Number of Packages" column.
4. Fold form in thirds, seal adhesive strip, affix postage, mail to: Provider Forms Distribution
   PO Box 14090
   Salem, Or 97309-4090

Provider Name		
Street Address		
City	State	Zip Code

Provider No.	Telephone No.

Forms

Available in Packages of 50

Form No.	Form Name	Quantity Requested	Number of Packages Requested
AFS 3067	**Provider's Form Request (maximum of 5 forms)**		
OMAP 501D	Dental Service Invoice (continuous)		
OMAP 502	Prescription Drug Invoice		
OMAP 502N	Prescription Drug Invoice (Narrow)		
OMAP 505	Medicare/Medicaid Billing Invoice (continuous)		
OMAP 741	Hysterectomy Consent		
OMAP 742	Consent To Sterilization		
OMAP 1036	Individual Adjustment Request		
OMAP 3066	Oregon Medicheck (EPSDT) Referral		
OMAP 3072	EPSDT Screening Instrument		
OMAP 405T	Medical Transportation Order		
OMAP 406	Medical Transp Eligibility Screening & Med Transportation Order		

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AFS 3067 (Rev. 12/94)

PLACE STAMP HERE

Adult and Family Services Division
Provider Forms Distribution
PO Box 14090
Salem OR 97309-4090

State of Oregon
Department of Human Resources
Office of Medical Assistance Programs

Send changes to: PRU – OMAP
Attn: Provider Enrollment
500 Summer St NE
Salem OR 97310-1014
Phone: 1-800-422-5047

Change of Provider Information

(Please print or type)

Current Provider Number	Date

Complete only the fields where information has changed

Provider Name

Business Name

Physical Location- Suite/Building

Building/Suite City State Zip

Mailing Address

Street City State Zip

Area Code - Telephone Number	County

IRS Number	Medicare/UPIN Number

SSN Number	CLIA Number

Drug Enforcement Agency Number	License Number (Professional or Pharmacy)

Organization	Hospitals - Facility Ownership

Physicians/Dentists - Specialty(s)

Official Signature Title

From

PLACE STAMP HERE
Without Stamp
Post Office
will return
mail to you

PRU – OMAP
Attn: Provider Enrollment
500 Summer St NE
Salem OR 97310-1014

HELP

I need help and I would like someone to call me.

- ❒ I have not billed the Office of Medical Assistance Programs.
- ❒ I have billed the Office of Medical Assistance Programs.
  - ❒ less than one year
  - ❒ more than a year
  - ❒ more than two years
- ❒ I have done other medical billing

ELECTRONIC CLAIMS

- ❒ Please send me general information about electronic billing capabilities.
- ❒ Please call me about electronic billing. I would like to know more about the billing option checked below:

  (Check as many as you wish)

  - ❒ Electronic billing services
  - ❒ Nine track magnetic tape
  - ❒ Modem
  - ❒ Floppy disk

Your Name: _____

Business Name: _____

Address: _____
Street **City** **State** **Zip**

Telephone Number: _____ Best time to call: _____

Provider number: | | | | | | |

Fold and mail

OMAP 3076 (7/91)

From

PLACE STAMP HERE
Without Stamp Post Office will return mail to you

PRU – OMAP
500 Summer St NE
Salem, Oregon 97310-1014

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
☐	☐	☐	☐	☐	☐	☐

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐
CITY / STATE	
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )	
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED DATE		PIN # GRP #

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90-1B

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

State of Oregon
Department of Human Resources
Office of Medical Assistance Programs

Individual Adjustment Request

- Complete this form to request an adjustment.
- Please keep your copy.

OMAP Use Only

1. Please Adjust (Indicate situation below)

❑ Underpayment - Request additional payment

❑ Overpayment - Please deduct from subsequent payment

2. To facilitate processing please attach the following:

- Claim (copy)
- Remittance Advice (copy)
- Financial planner (N.H. only)

3. Return To:

Office of Medical Assistance Programs
Department of Human Resources
PO Box 14952
Salem OR 97309

Please enter the following data from your Remittance Advice:

4. Internal Control Number

5. Client I.D. Number

6. Client Name

7. Provider Number

8. Provider Name

9. Remittance Advice Date

10. Description	11. Line No.	12. Service Date	13. Wrong Information	14. Right Information
❑ Place of Service				
❑ Type of Service				
❑ Quantity/Unit				
❑ NDC/Procedure Code				
❑ Revenue Center Code (Hospital Only)				
❑ Insurance Payment/Patient Liability				
❑ Drug Name (Pharmacy Only)				
❑ Billed Amount				
❑ Other				

15. Remarks

16. Provider's Signature

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17. Date

Distribution: White - OMAP; Canary - Provider

OMAP 1036 (Rev. 3/90)